Title II Comprehensive HIV/AIDS Care and Services Plan

for Ryan White Title II Funded Services in Utah

2006

Prepared by:
The Utah Department of Health for the
HIV Treatment and Care Planning Committee
December 2005

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Utah Department of Health
Bureau of Communicable Disease Control
HIV/AIDS Treatment and Care Program

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This is a copy of the Title II Comprehensive HIV/AIDS Care and Services Plan produced by the Utah Department of Health, Bureau of Communicable Disease Control with the assistance of the HIV Treatment and Care Planning Committee. Additional copies may be obtained by contacting the State HIV/AIDS Treatment and Care Program Office at (801) 538-6096 or 1-800-537-1046.

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We would like to acknowledge and express our sincere gratitude to the people living with HIV/AIDS in Utah who contributed their time and opinions to this report.

LETTER OF CONCURENCE

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January 30, 2006

Health Resources and Services Administration
HIV/AIDS Bureau
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Attn: Deborah Parham Hopson, Ph.D., R.N.

It is our pleasure to submit the 2006 Utah Title II Comprehensive HIV/AIDS Care and Services Plan. This document was developed by the State of Utah HIV Treatment and Care Planning Committee and the Utah Department of Health (UDOH). We are submitting this application for review and funding by the Health and Human Resources Administration.

The Utah HIV Treatment and Care Planning Committee and UDOH successfully collaborated in identifying and prioritizing a plan of care that ensures the availability of HIV-related services statewide. The committee agreed on the program priorities contained in this report. The HIV Treatment and Care Planning Committee went through the following steps to come to concurrence during monthly committee meetings:

- Review Data Sources:
  - Needs Assessment
  - Epidemiological Profile
  - Co-morbidity Data
  - Resource Directory
  - Clients Utilization Data
  - Statewide Coordinated Statement of Need (SCSN)
  - Unmet Needs and Service Gaps Report
  - Comprehensive Plan
  - Counseling and Testing Data
- Conduct/Review Needs Assessment
- Conduct/Review Gap Analysis
- Education of Service Categories
- Priority Setting
- Resource Allocation
- Evaluate Planning Process
- Develop Comprehensive Plan
- Prepare Grant Application

Sincerely,
HIV Treatment and Care Planning Committee Co-Chairs
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Acronyms and Definitions Used Within This Document

ADAP: AIDS Drug Assistance Program. This federal program administered by the Utah Department of Health pays for HIV/AIDS medications for uninsured or underinsured low-income individuals.

AIDS: Acquired immunodeficiency syndrome. AIDS is the condition that results from HIV infection and is marked by the presence of opportunistic infections that do not impact persons with healthy immune systems.

CARE Act: The Ryan White Comprehensive AIDS Resources Emergency Act is the primary federal legislation created to address the health and support services needs of persons living with HIV/AIDS and their families in the United States; enacted in 1990 and reauthorized in 1996 and 2000.

HIV: Human immunodeficiency virus. HIV is the virus that causes AIDS. Persons with HIV are referred to as HIV infected.

HIV+/aware: People that are HIV positive and are aware of their HIV status. This includes two groups: 1) People living with AIDS (PLWA) and 2) People living with HIV (PLWH).

HOPWA: Housing Opportunities for People Living With HIV/AIDS

In-care: A person is considered to be in-care when s/he is receiving HIV primary medical care during a 12-month period.

IDU: Injecting drug user.

MSM: Men who have sex with men.

MSM/IDU: Men who have sex with men and use injecting drugs.

Not in-care / Out of care: A person is considered to be out of care when s/he has not received HIV primary medical care during a 12-month period.

Population: An entire group or all cases; as defined by the researcher.

Prevalence: The total number of persons in a defined population living with a specific disease or condition at a given time.

PLWH/A: People Living With HIV/AIDS

Representative Sample: A sample that is similar to the population from which it is drawn is said to be representative and can be used to draw conclusions about the population.

Rural Areas: Rural areas are any areas that are not considered to be along the Wasatch Front. The Wasatch Front consists of four neighboring counties in Utah (Salt Lake, Weber, Davis, and Utah) that comprise the urban center, where the majority of the state's population resides.

Ryan White CARE Act: The Ryan White Comprehensive AIDS Resources Emergency Act

SCSN: The Statewide Coordinated Statement of Need.

Service Gaps: The need for other supportive services by individuals with HIV who are aware of their HIV status, but are not receiving other supportive services.

Title II (CARE Act): Provides formula grants to States, the District of Columbia, Puerto Rico, and eligible U.S. territories to improve the quality, availability, and organization of health care and support services for PLWH/A and their families.

Tx: Treatment

UDOH: Utah Department of Health

Unmet need: The need for HIV primary medical care by individuals with HIV who are aware of their HIV status, but are not receiving HIV primary medical care.

The Need for a Comprehensive Plan in Utah

The Utah Department of Health, Division of Communicable Disease Control, HIV/AIDS Treatment and Care Program, prepares the Comprehensive HIV/AIDS Plan every three years and updates the Plan annually in accordance with the Ryan White CARE Act. According to the federal Health Resources and Services Administration (HRSA), "Comprehensive HIV services planning provides a road map for developing a system of care over time. It does so by reviewing needs assessment data, existing resources to meet those needs, and barriers to care. This information is used to set out long-term goals, objectives, and strategies for delivering services. The plan also reflects the community's vision and values about how best to deliver HIV/AIDS care, particularly in light of limited resources." It is prepared through the collaborative efforts of the Utah Department of Health (UDOH) and members of the HIV Treatment and Care Planning Committee.

Documents reviewed for this report include:

- Utah HIV Prevention and HIV/AIDS Treatment and Care Needs Assessment Report
- HIV Surveillance Epidemiological Profile
- HIV/AIDS Co-morbidity Data
- HIV Treatment/Care Resource Inventory
- HIV/AIDS Title II Client Utilization Data
- Statewide Coordinated Statement of Need (SCSN)
- Gap Analysis Report
- Unmet Needs and Service Gaps Report
- Utah HIV/AIDS Comprehensive Plan
- Counseling and Testing Data

Executive Summary

SECTION 1
WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?
Epidemiological Profile

The number of persons living with HIV continues to increase each year. That increase is largely a result of improved treatment that has substantially delayed the onset of illness and death. Using methods recommended by the Centers for Disease Control (CDC), we estimate that at the end of 2003, there were about 2,000 persons (range from 1,700 to 2,600) living with HIV/AIDS in Utah. In addition to the increasing number of people in need of prevention and treatment and care services, these data suggest that there are a number of infected people who may not know they are infected. These people could benefit from treatment, and represent a risk of ongoing transmission.

Although most HIV/AIDS cases reported during 1998-2003 for both men and women have occurred among non-Hispanic White persons, the risk remains much higher for Hispanic and Black persons.

Most HIV/AIDS cases are men who have sex with men (MSM), but a notable increase occurred in 2002-2003 among MSM who inject drugs (MSM/IDU).

The age distribution of reported HIV/AIDS cases has changed little during the last several years. The percentage of cases among women has increased slightly.

SECTION 2
WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?
Continuum of Care for High Quality Core Services

Consistent with findings across the country, health disparities associated with the economic downturn, inadequate insurance coverage, changes in service eligibility criteria are increasing, especially among the working poor. PLWH/A

may be disproportionately affected since they are also confronted with an acute or chronic illness, often with co-morbidities, whose management may require access to very costly medications, frequent contact with health care professions and possible hospitalizations. Further, those who are eligible for CARE Act funding, are often also coping with poverty. To address these concerns, over the course of the year, the Treatment and Care Program will focus its planning and data collection efforts on:

- Defining and understanding the parameters associated with those who are not in care;
- Defining and proposing strategies for resolving unmet service needs;
- Expanding the collaboration with the HIV Prevention Program and Planning Committee;
- Client advocacy; and
- Program evaluation and recognition of best practices.

The HIV Treatment and Care Planning Committee and the HIV Prevention Community Planning Committee believe that these measures will allow them to better implement their essential goal of assuring that all people affected by HIV/AIDS have access to highest quality treatment, care and support.

SECTION 3
HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILIBILITY AND ACCESSIBILITY TO CORE SERVICES?

Goals and Objectives

The goal of the Title II program in the State of Utah is to provide for the development, organization, coordination and operation of a more effective and cost-efficient system for the delivery of essential services to individuals and families with HIV disease.

SECTION 4

HOW WILL WE MONIOTR OUR PROGRESS: HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT- AND LONG-TERM GOALS?

Implementation, Monitoring and Evaluation Plans

Evaluation is an essential element of the Comprehensive HIV/AIDS Plan. The HIV Treatment and Care Planning Committee and the Utah Department of Health, Bureau of Communicable Disease Control have the primary responsibility for monitoring the progress of the Comprehensive HIV/AIDS Plan's implementation. Throughout the next 3 years (2005-2007), these two entities will monitor the progress toward achievement of the goals and objectives, continue to gather information, update the Comprehensive HIV/AIDS Plan on a yearly basis, and evaluate the HIV Treatment and Care Planning Committee's planning process.

SECTION 1

WHERE ARE WE NOW: WHAT IS OUR CURRENT SYSTEM OF CARE?

Epidemiological Profile

Description of the Eligible Metropolitan Area/State

Population: In the 2000 Census the total population for Utah was 2,233,169 persons. Utah comprises 29 counties with populations that range from a low 921 persons (Daggett County) to almost 900,000 persons in Salt Lake County. Regionally, 76% of the state's population reside within 4 neighboring counties (Salt Lake, Weber, Davis and Utah) that comprise the urban center.
This area, which represents less than 5% of the states landmass, spans 130 miles along the base of the Wasatch Mountain range. This corridor is referred to as the Wasatch Front. The remaining 25 counties are considered rural or frontier. These remaining counties are often classified together as the non-Wasatch region.

Public Health Structure: The State of Utah is divided into 12 local and district health departments. These regionally distinct health departments are comprised of 1-6 adjoining counties. Each local health department has a central office that coordinates and provides services for the region, both on and off site.

Demographic Composition: According to the 2000 Census data, the racial and ethnic composition of the State of Utah was estimated to be 85% White non-Hispanic, 9% Hispanic, 0.9% Black non-Hispanic, 1.4% Native American or Alaskan Native non-Hispanic, and Asian and Pacific Islander non-Hispanic made up 2.4% of the total population. Utah's Black, Asian and Pacific Islander, and Hispanic populations are growing at faster rates than the state population as a whole.

Age and Sex: In 2000, the median age of Utah residents was 27.1, and 54% of the population was <30 years of age. The proportion of males to females is almost even. (50.1% vs. 49.9%)

Household Structure: At the time of the 2000 Census, there were a total of 126,183 Utah children under age six and 411,780 children under age 18 who had both parents in the labor force. Of the total number of families, 9.4% had a female head of household (no husband present). A majority (63%) of Utah households include a married couple, either with or without children. While most couples in the U.S. do not have children living with them, the majority of married couples in Utah do have children present.

Poverty, Income and Education: In the 2000 Census, the median household income in Utah was $45,726. The Census also reported 9.4% of the population were living below the poverty level, according to federal definition; with 6.5% of all Utah families below the poverty level. In the most recent 2002 data, 228,000 Utahns were living in poverty and 94,000 of them were children age 17 or under. The annual unemployment rate in 2000 was 4.0% statewide. In 2000, Utah ranked 45th among states for per capita income.

Health Indicators: According to the 2004 edition of America's Health State Health Ranking, Utah ranked third in the list of healthiest states for 2003; it was fourth in 2002. Our greatest strengths include a low prevalence of smoking at 12.7 percent of the population, a low rate of deaths from heart disease at 191.8 deaths per 100,000 population, and a low rate of cancer deaths at 164.5 deaths per 100,000 population. It is also among the top 10 states for a low violent crime rate, a strong high school graduation rate, a low total mortality rate, a low infant mortality rate and a low 4 Utah Department of Health premature death rate. Utah's challenges are low rates of early prenatal care with 58.4 percent of

pregnant women receiving adequate prenatal care and a higher than average occupational fatalities rate at 5.9 deaths per 100,000 workers.

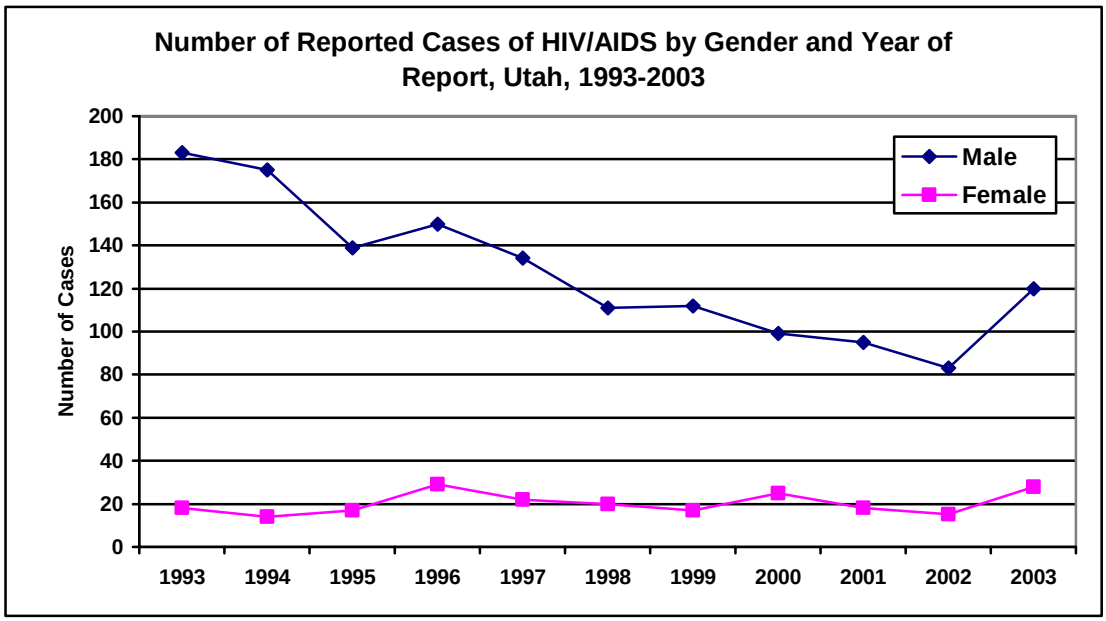
Health Insurance Coverage and Public Aid: An estimate of 214,500 Utahns (9.1%) were without health insurance coverage in 2003. This percentage has increased from an estimated 7.6% in 1996, and 8.7% in 2001 when the last Health Status Survey was conducted. In 1993, Utah ranked first for the percentage of persons covered by health insurance. Since then, the percentage of insured Utahns has steadily decreased, and in 2003 Utah fell to 22nd. In 2003, approximately 7.2% of Utah children, ages 0-18, were unprotected by any type of health insurance coverage. Approximately 83% of uninsured children in Utah are eligible for health care services through either CHIP or Medicaid programs. Demographically, younger persons, especially males age 19 to 26, and those with low-income levels, are at greater risk of being uninsured. Surprisingly, over two-thirds of uninsured Utah adults in 2003 were working either part or full-time.

CDC/HRSA Epidemiological Profile

Current Local/State Epidemic

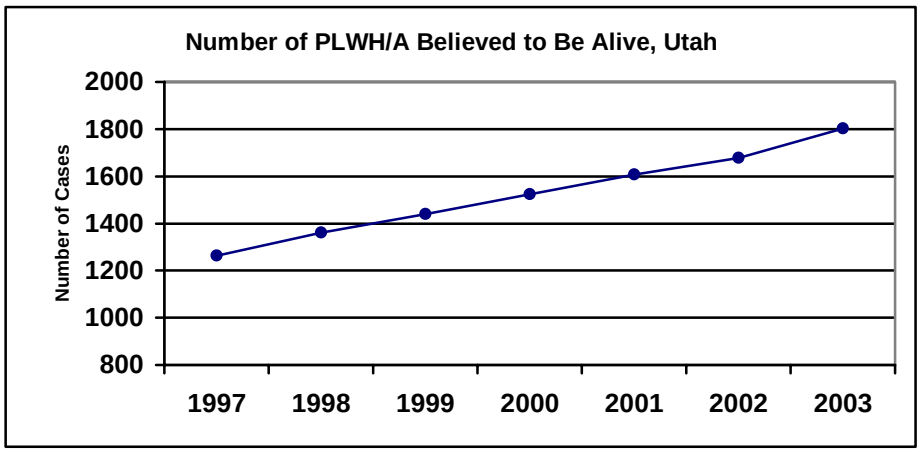
The number of HIV infections and AIDS cases has declined steadily since 1993. This trend has also occurred nationally. Incidence rates have decreased from a peak of 14.4 cases per 100,000 persons in 1990, to 3.4 cases per 100,000 in 2002. An increase was observed, however, during the 2002-2003 time period among both men and women. The increase was more pronounced for men than women. The 2003 case rate was 4.7 cases per 100,000 persons.

Table 1



The number of people living with HIV an AIDS continues to increase. The number of people living with HIV infection who require treatment and care, and who carry the potential for further transmission will continue to increase during the years to come. The following table illustrates the number of presumed living cases of HIV/AIDS.

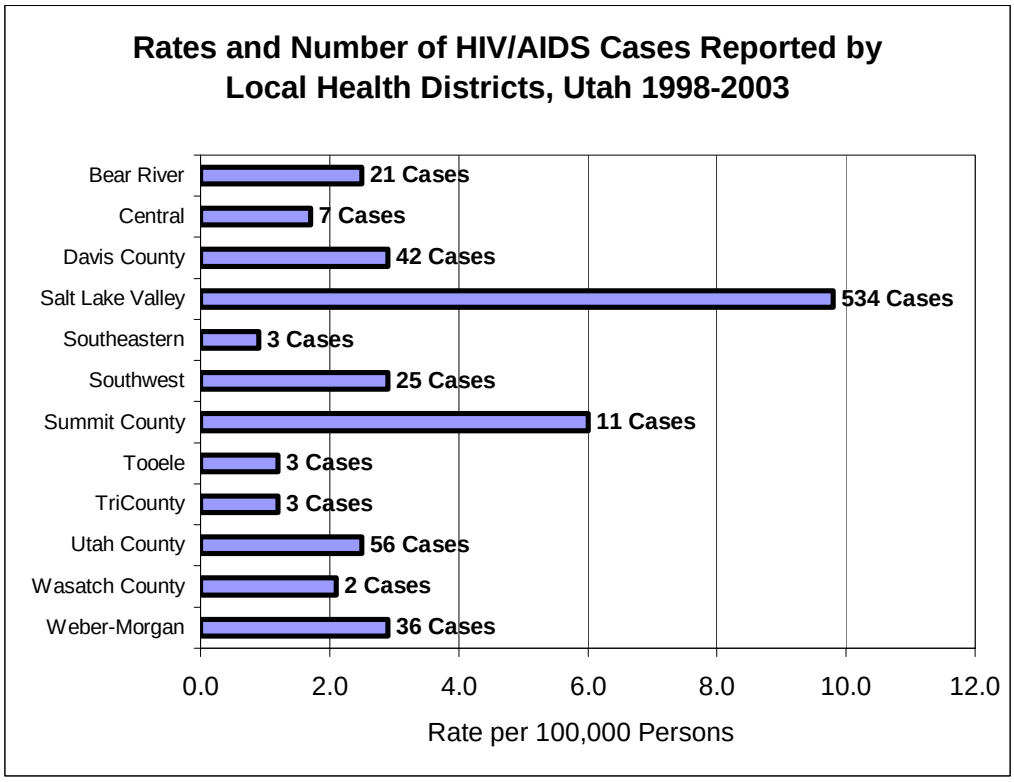
Table 2



Year	1997	1998	1999	2000	2001	2002	2003
Cases	1,262	1,360	1,439	1,522	1,608	1,679	1,803

Utah is similar to most of the United States in that HIV/AIDS has been disproportionately concentrated in urban areas. The following table shows both rates (lengths of bars) and numbers of cases (numbers at the end of bars). Ninety-one percent of HIV/AIDS cases reported during 1998-2003 occurred along the Wasatch Front, with 72% being residents of Salt Lake County, which also had the highest rate (9.8/100,000). Rates in health districts with few cases should be interpreted cautiously.

Table 3



Although most HIV/AIDS cases reported during 1998-2003 for both men and women have occurred among non-Hispanic White persons, the number of cases that occurred among Hispanic and Black people were greatly disproportionate to the size of those two populations. Other notes of interest pertaining to race/ethnicity include:

- Most Hispanic persons (65%) reported their country of origin as other than the United States.
- Two-thirds of persons reported as risk "not specified" were in populations other than White non-Hispanic. Most were males, in the age group 20-39.
- The majority of Black persons (61%) reported with HIV/AIDS in Utah during 1998-2003 were from African nations, 35% were from the United States.

Table 4
Number of Persons Believed to be Living with HIV/AIDS by Race/Ethnicity, Utah, Through December 31, 2003

Population	Number (%)
African/African American	84 (7%)
American Indian	16 (1%)
Asian – Pacific Islander	14 (1%)
Hispanic	186 (15%)
White	937 (75%)
Unknown	6 (<1%)
TOTAL	1,243

Overall, few changes have occurred in the statewide pattern of HIV/AIDS cases when examined by age, sex, race/ethnic groups and exposure groups.

- The majority of cases continue to occur among men who have sex with men (MSM).
- The second largest group is related to injecting drug use (IDU), including injecting drug users and those who acquired the infection through sexual contact with injecting drug users.
- The major risk for HIV/AIDS infected women during 1998-2003 was heterosexual contact (33%), followed by injecting drug use (25%). For 26%, risk was not specified. Forty-two percent of HIV/AIDS cases among women were reported in the age group 20-29.

Table 5

Number of Persons Believed to be Living with HIV/AIDS by Mode of Exposure, Utah, Through December 31, 2003

Risk Group	Number (%)
MSM	723 (58%)
IDU	177 (14%)
MSM/IDU	115 (9%)
Heterosexual Contact	120 (10%)
Other Risk	31 (2%)
Not Specified	77 (6%)
TOTAL	1,243

- Most persons living with HIV or AIDS are between the ages of 20 and 39 years. This is consistent with findings in most US communities. A concern that arises in these statistics is the possibility that those PLWH/A who are diagnosed in their 20s may have actually been infected in their teens.

Table 6

Number of Persons Believed to be Living with HIV/AIDS by Age, Utah, Through December 31, 2003

Age Range	Number (%)
0-12	10 (1%)
13-19	48 (4%)
20-29	417 (34%)
30-39	502 (40%)
40-49	198 (16%)
50+	68 (5%)
TOTAL	1,243

- There has been a gradual shift toward an increased percentage of cases occurring among people, especially women, of color. The following table

shows the distribution of new cases of HIV/AIDS by gender and race/ethnicity from 1998-2001.

Table 7

Number of New Cases HIV/AIDS by Gender and Race/Ethnicity, 1998-2001

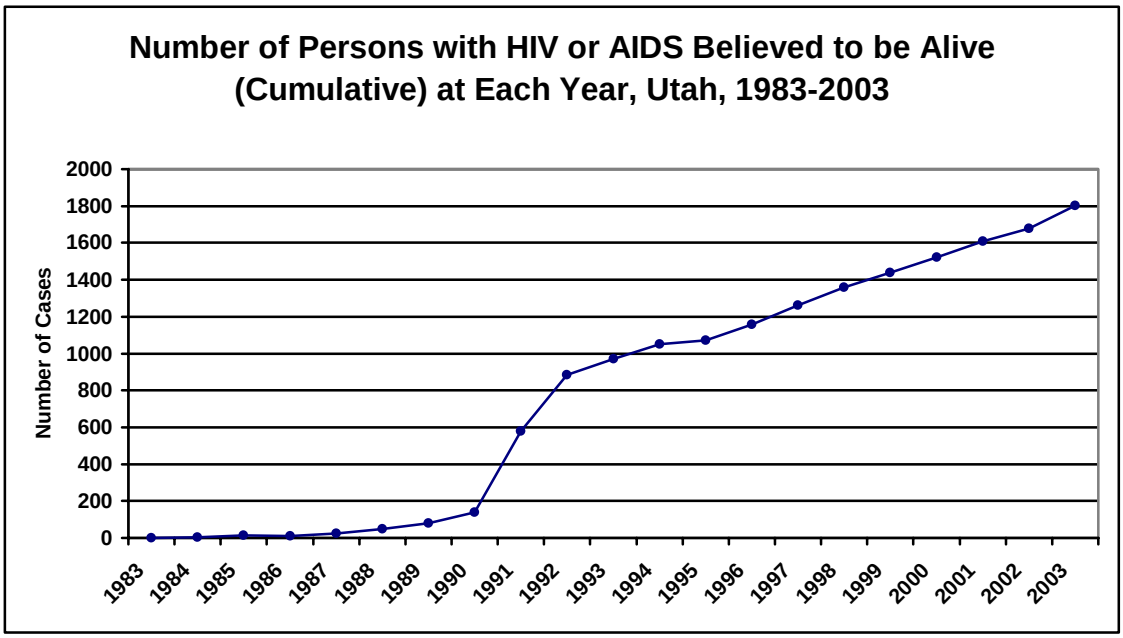
Group	Male			Female		
	#	%	Rate	#	%	Rate
African/African American	48	8	75.3	34	28	53.4
American Indian	10	2	10.8	2	2	2.2
Asian – Pacific Islander	9	1	5.5	4	3	2.4
Hispanic	137	22	22.4	26	21	4.3
White	411	66	7.0	54	44	0.9
TOTAL	620	100%	9.1	123	100%	1.8

Future Trends

The number of persons living with HIV continues to increase each year as shown in Table 8. That increase is largely a result of improved treatment that has substantially delayed the onset of illness and death. These data represent only those cases known based on reporting. Using calculation methods recommended by the CDC, we estimate that at the end of 2003, there were about 2,000 persons (range from 1,700 to 2,600) living with HIV/AIDS in Utah.

In addition to the increasing number of people in need of prevention and treatment and care services, these data suggest that there are a number of infected people who may not know they are infected. Those people could benefit from treatment, and represent a risk of ongoing transmission.

Table 8



The increase in the number of people living with HIV disease has greatly focused our efforts toward HIV treatment and care, HIV prevention interventions, community participation and resource utilization.

Description of the History of Local, State and/or Regional Response to the Epidemic

On August 18, 1990, Congress passed Public Law 101-381 entitled The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (the Act). The purpose of the Act was to provide "emergency assistance to localities disproportionately affected by the Human Immunodeficiency Virus (HIV) epidemic and to make financial assistance available to states and other public and private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individuals and families with HIV disease."

The Act was created to establish services for patients with Acquired Immunodeficiency Syndrome (AIDS) or HIV who would otherwise have no access to health care. It was meant to provide emergency relief funding to communities with the highest number of reported AIDS cases.

In 1990, the Utah HIV Coordination of Care Council was established. This Council served as the entity responsible fro Consortia activities. Through a lead agency, the Consortium was responsible for planning and implementing Ryan White Title II Supportive Services. In 1999, the Consortium underwent significant changes. The Utah Department of Health, with technical assistance provided by HRSA, came to the conclusion that the Consortium's planning activities were too limited. It was decided that a larger planning body should be established to look at one hundred percent of the Title II funds rather than the twenty five percent in the supportive services only the consortium was then overseeing.

The Utah Department of Health first proposed an integrated treatment/care and prevention education planning group in September, 1999. The goal of this integration was to improve and enhance participation and resource utilization in HIV prevention and care. This effort would help forge linkages across the disciplines of HIV treatment and care and prevention education, ultimately improving access to primary medical care and prevention services.

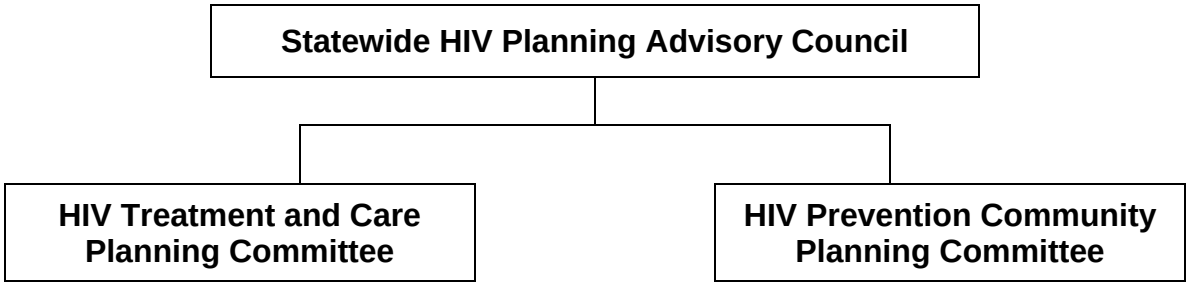
The Utah HIV Planning Advisory Council met for the first time in February 2000. The meeting was successful with a rich discussion occurring between members of the prevention and treatment and care communities. Throughout this process, the focus has been on three key issues:

1. Keeping a clear vision of the need for a statewide integrated planning process. As more people are living with HIV disease in Utah, the need to wisely steward our resources is critical.

2. This change is being done to promote increased consumer and community participation in the greater, statewide context of HIV planning. The needs of the entire state must be presented in all discussions.
3. Everyone involved in the prevention and care continuum will benefit from the collective input or experience of prevention and treatment and care partners working together.

Table 9

Statewide HIV Planning Council Organizational Chart



The purpose of the Utah HIV Planning Advisory Council (The Council) is to oversee the development of the annual Comprehensive HIV/AIDS Plan. The Comprehensive HIV/AIDS Plan serves as the guiding document for policy makers, health planners and community representatives. The Council also serves as a mechanism to promote integration of HIV Treatment and Care services with HIV Education and Prevention activities. Strong emphasis is placed on actualizing the prevention-care-prevention continuum through joint meetings, shared membership and collaborative projects. The Council has approximately 65 members. The Council members are individuals who serve on the HIV Treatment and Care Planning Committee and/or the HIV Prevention Community Planning Committee.

The purpose of the HIV Treatment and Care Planning Committee is to develop the Title II Comprehensive HIV/AIDS Care and Services Plan. In developing the

Title II Comprehensive HIV/AIDS Care and Services Plan, the Committee shall attempt to (a) improve and enhance community participation in statewide HIV planning; b) maximize resources and reduce duplication of efforts for treatment and care planning and evaluation; and c) look at all treatment and care services which includes, but is not limited to: Ryan White Title II programs, Housing Opportunities for People With AIDS, Medicaid, and Ryan White Title III.

HIV Medical Care Needs (Core and Other Support Services)

The Ryan White Title II Program goal is to improve the quality, availability and organization of heath care and supportive services for individuals living with HIV disease and their families. The following programs are within the the Ryan White Title II Program:

- AIDS Drug Assistance Program (ADAP) – helps pay for medications for PLWH/A.
- ADAP Private Insurance Co-pay Program – if an individual with HIV/AIDS has their own private insurance, but cannot afford the cost of co-pays, the APICP program can help pay part or all of their HIV medication co-pays.
- Health Insurance Program (HIP) – helps PLWH/A pay for insurance payments, co-pays and deductibles. Can also pay for COBRA payments for health insurance continuation.
- Supportive Services Program – Various services available for PLWH/A:
    - Core Services include:
        - Ambulatory/Outpatient Medical Care
        - Oral Health Care (Dental)
        - Case Management
    - Other Services include:
        - Mental Health Services
        - Substance Abuse Services
        - Transportation Services
        - Emergency Food Vouchers
        - Housing Services

- Home Health Care

Unmet Needs Estimate

The goal of this study was to identify people living with HIV or AIDS in Utah, who know their HIV status, and are not receiving HIV-related services. The results will be used to inform policy and resource allocation decisions pertaining to HIV-related services in Utah. Another goal of this study is to ensure compliance with CARE Act mandates that require Title II grantees to determine the unmet need and service gaps in their respective states. The Ryan White CARE Act contains multiple provisions for enhancing access to HIV-related services for people living with HIV who are not in care. This study seeks to identify people living with HIV who are not in care so that efforts can be made to get them into care.

The HIV/AIDS Treatment and Care Program, under the Utah Department of Health Bureau of Communicable Disease Control, conducted the study. The project findings are part of a comprehensive look at the needs of individuals in Utah who are HIV positive and aware of their HIV status and should be used in conjunction with an epidemiological profile, needs assessment data, and similar documents. Underlying trends and facts derived from the data that might be useful in planning and decision-making are presented after the methodology section.

The population in this study is HIV+/aware individuals living in Utah. This population does not include people that are HIV+/unaware because it is difficult to assess the HIV-related needs of people that do not know they are HIV positive. The HIV+/aware population was separated into PLWA and PLWH populations because care patterns usually differ depending on the stage of the disease.

The HIV/AIDS Reporting System (HARS) and the Ryan White Database were the two data sources used in this study. The HIV/AIDS Surveillance Program maintains the HARS data and the HIV/AIDS Treatment and Care Program

maintains the Ryan White Database. All data was corrected for in-migration and out-migration so that a better estimate of unmet need and service gaps could be calculated.

All analyses used in this study are estimations due to the challenges faced in identifying PLWH and PLWA that are not in-care. Since they are not in-care, there isn't a current record or report that identifies them for study participation. Due to this challenge, estimation is the best attempt in identifying the number of PLWH and PLWA that are not in-care. The prevalence data used in the estimation analyses is cumulative through June 30, 2003. The 12-month period used to define "in-care" was from July 1, 2002 through June 30, 2003. PLWH and PLWA that received primary medical care within that 12-month period were considered to be in-care.

- *Unmet Need by Population*

The combined population results indicate that there are 364 (24.2%) HIV+/aware individuals in Utah that are not in care. This number includes 185 PLWH and 179 PLWA. The PLWH population demonstrated a higher level of unmet need (*n* = 185; 34.5%) than the PLWA population (*n* = 179; 18.5%). This means that there are more people out of care in the PLWH population than in the PLWA population. A possible explanation of the results observed is that PLWH are not as likely to experience symptoms that would persuade them to seek primary medical care. As a result, PLWH have a higher level of unmet need. The opposite is true for the PLWA population. PLWA are more likely to experience symptoms that would persuade them to seek primary medical care so there is a lower level of unmet need.

Table 10
Unmet Need Estimates Listed by Population

	PLWH			PLWA			HIV+/aware Population		
Variable	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**
Total	537	352	185	965	786	179	1,502	1,138	364
	100.0%	**65.5%**	**34.5%**	**100.0%**	**81.5%**	**18.5%**	**100.0%**	**75.8%**	**24.2%**

Note. Discrepancies are due to rounding.

- *Unmet Need by Demographic Group*

The percentages represent the proportion of the individual demographic represented in a particular category and is depicted in a bold font style. The numbers above the percents represent the number of individuals within a particular category. It is important consider the percent and the number when interpreting the results, given that percents can be misleading when interpreted independently. For example, in the PLWA unmet need column, males and females both have approximately 18% (Male = 18.6%; Female = 17.8%) listed as their unmet need percent. On the other hand, 18% in the Male demographic represents 161 males where 18% in the Female demographic represents 18 females.

Table 11
Unmet Need Estimates Listed by Demographic Group.

	PLWH			PLWA			HIV+/aware Population		
Variable	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**
Gender									
Male	428	272	156**	864	703	161**	1,292	975	317**
	100.0%	**63.6%**	**36.4%**	**100.0%**	**81.4%**	**18.6%**	**100.0%**	**75.5%**	**24.5%**
Female	109	80	29	101	83	18	210	163	47
	100.0%	**73.4%**	**26.6%**	**100.0%**	**82.2%**	**17.8%**	**100.0%**	**77.6%**	**22.4%**
Total	537	352	185	965	786	179	1,502	1,138	364
	100.0%	**65.5%**	**34.5%**	**100.0%**	**81.5%**	**18.5%**	**100.0%**	**75.8%**	**24.2%**

Table 11 continued on next page

	PLWH			PLWA			HIV+/aware Population		
Variable	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**
Exposure Category									
MSM	295	189	106	572	483	89	867	672	195
	100.0%	**64.1%**	**35.9%**	**100.0%**	**84.4%**	**15.6%**	**100.0%**	**77.5%**	**22.5%**
IDU	77	41	36**	164	121	43**	241	162	79**
	100.0%	**53.2%**	**46.8%**	**100.0%**	**73.8%**	**26.2%**	**100.0%**	**67.2%**	**32.8%**
MSM/IDU	38	32	6	86	65	21	124	97	27
	100.0%	**84.2%**	**15.8%**	**100.0%**	**75.6%**	**24.4%**	**100.0%**	**78.2%**	**21.8%**
Heterosexual	62	44	18	72	62	10	134	106	28
	100.0%	**71.0%**	**29.0%**	**100.0%**	**86.1%**	**13.9%**	**100.0%**	**79.1%**	**20.9%**
Other	7	6	1	34	25	9	41	31	10
	100.0%	**85.7%**	**14.3%**	**100.0%**	**73.5%**	**26.5%**	**100.0%**	**75.6%**	**24.4%**
Unknown	58	40	18	37	30	7	95	70	25
	100.0%	**69.0%**	**31.0%**	**100.0%**	**81.1%**	**18.9%**	**100.0%**	**73.7%**	**26.3%**
Total	537	352	185	965	786	179	1,502	1,138	364
	100.0%	**65.5%**	**34.5%**	**100.0%**	**81.5%**	**18.5%**	**100.0%**	**75.8%**	**24.2%**
Geographic Location									
Wasatch Front	466	308	158	823	674	149	1289	982	307
	100.0%	**66.1%**	**33.9%**	**100.0%**	**81.9%**	**18.1%**	**100.0%**	**76.2%**	**23.8%**
Non-Wasatch Front	71	44	27**	142	112	30**	213	156	57**
	100.0%	**62.0%**	**38.0%**	**100.0%**	**78.9%**	**21.1%**	**100.0%**	**73.2%**	**26.8%**
Total	537	352	185	965	786	179	1,502	1,138	364
	100.0%	**65.5%**	**34.5%**	**100.0%**	**81.5%**	**18.5%**	**100.0%**	**75.8%**	**24.2%**
Age Group									
0-9	5	5	0	3	3	0	8	8	0
	100.0%	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**
10-19	19	14	5	11	8	3**	30	22	8
	100.0%	**73.7%**	**26.3%**	**100.0%**	**72.7%**	**27.3%**	**100.0%**	**73.3%**	**26.7%**
20-29	208	129	79**	174	135	39	382	264	118**
	100.0%	**62.0%**	**38.0%**	**100.0%**	**77.6%**	**22.4%**	**100.0%**	**69.1%**	**30.9%**
30-39	199	131	68	440	359	81	639	490	149
	100.0%	**65.8%**	**34.2%**	**100.0%**	**81.6%**	**18.4%**	**100.0%**	**76.7%**	**23.3%**
40-49	86	57	29	261	217	44	347	274	73
	100.0%	**66.3%**	**33.7%**	**100.0%**	**83.1%**	**16.9%**	**100.0%**	**79.0%**	**21.0%**
50 and over	20	16	4	76	64	12	96	80	16
	100.0%	**80.0%**	**20.0%**	**100.0%**	**84.2%**	**15.8%**	**100.0%**	**83.3%**	**16.7%**
Total	537	352	185	965	786	179	1,502	1,138	364
	100.0%	**65.5%**	**34.5%**	**100.0%**	**81.5%**	**18.5%**	**100.0%**	**75.8%**	**24.2%**

Table 11 continued on next page

	PLWH			PLWA			HIV+/aware Population		
Variable	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**
Race/ Ethnicity									
White, not Hispanic	385	251	134	728	614	114	1,113	865	248
	100.0%	**65.2%**	**34.8%**	**100.0%**	**84.3%**	**15.7%**	**100.0%**	**77.7%**	**22.3%**
Black, not Hispanic	47	30	17	69	52	17	116	82	34
	100.0%	**63.8%**	**36.2%**	**100.0%**	**75.4%**	**24.6%**	**100.0%**	**70.7%**	**29.3%**
Hispanic	80	56	24	142	101	41	222	157	65
	100.0%	**70.0%**	**30.0%**	**100.0%**	**71.1%**	**28.9%**	**100.0%**	**70.7%**	**29.3%**
Asian/Pacific Islander	6	4	2	12	10	2	18	14	4
	100.0%	**66.7%**	**33.3%**	**100.0%**	**83.3%**	**16.7%**	**100.0%**	**77.8%**	**22.2%**
Am. Indian/ Alaskan Native	10	6	4**	14	9	5**	24	15	9**
	100.0%	**60.0%**	**40.0%**	**100.0%**	**64.3%**	**35.7%**	**100.0%**	**62.5%**	**37.5%**
Not Specified	9	5	4	0	0	0	9	5	4
	100.0%	**55.6%**	**44.4%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**55.6%**	**44.4%**
Total	537	352	185	965	786	179	1,502	1,138	364
	100.0%	**65.5%**	**34.5%**	**100.0%**	**81.5%**	**18.5%**	**100.0%**	**75.8%**	**24.2%**

Note. Discrepancies are due to rounding. Wasatch Front area includes the following counties: Weber, Davis, Salt Lake, and Utah. MSM stands for "men who have sex with men." IDU stands for "injecting drug users." Unknown in exposure category is risk not reported or identified. ** identifies the highest unmet need.

The highest levels of unmet need are summarized in Table 12. The "Other," "Unknown," and "Not Specified" categories were not considered in this table.

Table 12
Highest Unmet Need

	PLWH			PLWA			HIV+/aware Population		
Variable	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**
Gender									
Male	428	272	156	864	703	161	1,292	975	317
	100.0%	**63.6%**	**36.4%**	**100.0%**	**81.4%**	**18.6%**	**100.0%**	**75.5%**	**24.5%**
Exposure Category									
IDU	77	41	36	164	121	43	241	162	79
	100.0%	**53.2%**	**46.8%**	**100.0%**	**73.8%**	**26.2%**	**100.0%**	**67.2%**	**32.8%**
Geographic Location									
Non-Wasatch Front	71	44	27	142	112	30	213	156	57
	100.0%	**62.0%**	**38.0%**	**100.0%**	**78.9%**	**21.1%**	**100.0%**	**73.2%**	**26.8%**

Table 12 continued on next page

	PLWH			PLWA			HIV+/aware Population		
Variable	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**	**Prevalence**	**In-care**	**Unmet Need**
Age Group									
10-19	19	14	5	11	8	3**	30	22	8
	100.0%	**73.7%**	**26.3%**	**100.0%**	**72.7%**	**27.3%**	**100.0%**	**73.3%**	**26.7%**
20-29	208	129	79**	174	135	39	382	264	118**
	100.0%	**62.0%**	**38.0%**	**100.0%**	**77.6%**	**22.4%**	**100.0%**	**69.1%**	**30.9%**
Race/ Ethnicity									
Black, not Hispanic	47	30	17	69	52	17	116	82	34
	100.0%	**63.8%**	**36.2%**	**100.0%**	**75.4%**	**24.6%**	**100.0%**	**70.7%**	**29.3%**
Hispanic	80	56	24	142	101	41	222	157	65
	100.0%	**70.0%**	**30.0%**	**100.0%**	**71.1%**	**28.9%**	**100.0%**	**70.7%**	**29.3%**
Am. Indian/ Alaskan Native	10	6	4**	14	9	5**	24	15	9**
	100.0%	**60.0%**	**40.0%**	**100.0%**	**64.3%**	**35.7%**	**100.0%**	**62.5%**	**37.5%**

** identifies the highest unmet need.

The male, IDU, and Non-Wasatch Front categories demonstrated the highest level of unmet need. The unmet need was consistent across all populations in these categories. The age and race/ethnicity demographics were exceptions to the consistency in unmet need. In the age demographic, the 10-19 age group had the highest level of unmet need in the PLWA population. On the other hand, there were only three people out of eleven that demonstrated unmet need. These small numbers have inflated the percent estimate (27.3%) so the estimate should be interpreted cautiously. It would be better to consider both the 10-19 and 20-29 age groups as the groups with the highest level of unmet need in the age demographic in the PLWA population. The 20-29 age group is the group with the highest level of unmet need in the age demographic in the PLWH and HIV+/aware populations. It is important to remember that the HIV+/aware population includes the PLWH and PLWA populations.

The race/ethnicity demographic includes an inflation similar to the one observed in the age demographic as well as disproportionate unmet need between populations. The inflation occurred in the American Indian/Alaskan Native category. The small numbers in this category inflated the estimates and should

be interpreted cautiously. It would be better to take a comprehensive look at the Black, Hispanic, and American Indian/Alaskan Native categories to understand the unmet need according to race/ethnicity. The disproportionate unmet need occurred in the Black and Hispanic categories. Blacks had a higher level of unmet need in the PLWH population whereas Hispanics had a higher level of unmet need in the PLWA population. Blacks and Hispanics had an equal level of unmet need when the PLWH and PLWA populations were combined in the HIV+/aware population.

It is important to emphasize the relationship between unmet need and service gaps before discussing the significance of the service gap findings. Service gaps represent a portion of the unmet need. Unmet need reflects the experience of two HIV+/aware groups, which can be broken down as follows:

1) Those who received other supportive services but did not receive primary medical care (unmet need but used other services) and
2) Those who did not receive any services (service gap).

It should be noted that there were only 13 PLWA (7.3% of unmet need) and 5 PLWH (2.7% of unmet need) who used other supportive services but were not in primary medical care. This means that a majority of those with unmet needs (unmet need estimate) were not using other supportive services (service gap estimate) as well.

- *Service Gaps by Population*

The service gap estimates listed by population are presented in Table 13. The combined population results indicate that there are 346 (95.0% of unmet need results) HIV+/aware individuals in Utah that are not receiving any services. This number includes 166 (92.7% of unmet need) PLWA and 180 (97.3% of unmet need) PLWH.

Table 13
Service Gap Estimates Listed by Population

	PLWH			PLWA			HIV+/aware Population		
Variable	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**
Total	185	5	180	179	13	166	364	18	346
	100.0%	**2.7%**	**97.3%**	**100.0%**	**7.3%**	**92.7%**	**100.0%**	**4.9%**	**95.1%**

Note. Discrepancies are due to rounding.

- *Service Gaps by Demographic Group*

Service gaps listed by demographic group are presented in Table 14. The difference between unmet need and service gaps in the PLWH population was 5 (2.7% of unmet need) and it was 13 (7.3% of unmet need) in the PLWA population. These differences are relatively small when compared to the overall prevalence data. The difference of 13 is 1.3% of the PLWA population and the difference of 5 is 0.9% of the PLWH population. This is a result of the overlap between unmet need and service gaps. Due to the small differences, further explanation of the service gaps is not included in this report. The service gaps represent 92.7% of the PLWA unmet need and 97.3% of the PLWH unmet need. In other words, a majority of individuals with unmet needs are not using any other services as well.

Table 14
Service Gap Estimates Listed by Demographic Group

	PLWH			PLWA			HIV+/aware Population		
Variable	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**
Gender									
Male	156	3	153	161	11	150	317	14	303
	100.0%	**1.9%**	**98.1%**	**100.0%**	**6.8%**	**93.2%**	**100.0%**	**4.4%**	**95.6%**
Female	29	2	27	18	2	16	47	4	43
	100.0%	**6.9%**	**93.1%**	**100.0%**	**11.1%**	**88.9%**	**100.0%**	**8.5%**	**91.5%**
Total	185	5	180	179	13	166	364	18	346
	100.0%	**2.7%**	**97.3%**	**100.0%**	**7.3%**	**92.7%**	**100.0%**	**4.9%**	**95.1%**

Table 13 continued on next page

	PLWH			PLWA			HIV+/aware Population		
Variable	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**
Exposure Category									
MSM	106	2	104	89	8	81	195	10	185
	100.0%	**1.9%**	**98.1%**	**100.0%**	**9.0%**	**91.0%**	**100.0%**	**5.1%**	**94.9%**
IDU	36	1	35	43	2	41	79	3	76
	100.0%	**2.8%**	**97.2%**	**100.0%**	**4.7%**	**95.3%**	**100.0%**	**3.8%**	**96.2%**
MSM/IDU	6	1	5	21	1	20	27	2	25
	100.0%	**16.7%**	**83.3%**	**100.0%**	**4.8%**	**95.2%**	**100.0%**	**7.4%**	**92.6%**
Hetero-sexual	18	0	18	10	1	9	28	1	27
	100.0%	**0.0%**	**100.0%**	**100.0%**	**10.0%**	**90.0%**	**100.0%**	**3.6%**	**96.4%**
Other	1	0	1	9	1	8	10	1	9
	100.0%	**0.0%**	**100.0%**	**100.0%**	**11.1%**	**88.9%**	**100.0%**	**10.0%**	**90.0%**
Unknown	18	1	17	7	0	7	25	1	24
	100.0%	**5.6%**	**94.4%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**4.0%**	**96.0%**
Total	185	5	180	179	13	166	364	18	346
	100.0%	**2.7%**	**97.3%**	**100.0%**	**7.3%**	**92.7%**	**100.0%**	**4.9%**	**95.1%**
Geographic Location									
Wasatch Front	158	5	153	149	13	136	307	18	289
	100.0%	**3.2%**	**96.8%**	**100.0%**	**8.7%**	**91.3%**	**100.0%**	**5.9%**	**94.1%**
Non-Wasatch Front	27	0	27	30	0	30	57	0	57
	100.0%	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**
Total	185	5	180	179	13	166	364	18	346
	100.0%	**2.7%**	**97.3%**	**100.0%**	**7.3%**	**92.7%**	**100.0%**	**4.9%**	**95.1%**
Age Group									
0-9	0	0	0	0	0	0	0	0	0
	0.0%	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
10-19	5	0	5	3	0	3	8	0	8
	100.0%	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**
20-29	79	1	78	39	1	38	118	2	116
	100.0%	**1.3%**	**98.7%**	**100.0%**	**2.6%**	**97.4%**	**100.0%**	**1.7%**	**98.3%**
30-39	68	0	68	81	5	76	149	5	144
	100.0%	**0.0%**	**100.0%**	**100.0%**	**6.2%**	**93.8%**	**100.0%**	**3.4%**	**96.6%**
40-49	29	3	26	44	6	38	73	9	64
	100.0%	**10.3%**	**89.7%**	**100.0%**	**13.6%**	**86.4%**	**100.0%**	**12.3%**	**87.7%**
50 and over	4	1	3	12	1	11	16	2	14
	100.0%	**25.0%**	**75.0%**	**100.0%**	**8.3%**	**91.7%**	**100.0%**	**12.5%**	**87.5%**
Total	185	5	180	179	13	166	364	18	346
	100.0%	**2.7%**	**97.3%**	**100.0%**	**7.3%**	**92.7%**	**100.0%**	**4.9%**	**95.1%**

Table 14 continued on next page

	PLWH			PLWA			HIV+/aware Population		
Variable	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**
Race/ Ethnicity									
White, not Hispanic	134	5	129	114	9	105	248	14	234
	100.0%	**3.7%**	**96.3%**	**100.0%**	**7.9%**	**92.1%**	**100.0%**	**5.6%**	**94.4%**
Black, not Hispanic	17	0	17	17	3	14	34	3	31
	100.0%	**0.0%**	**100.0%**	**100.0%**	**17.6%**	**82.4%**	**100.0%**	**8.8%**	**91.2%**
Hispanic	24	0	24	41	1	40	65	1	64
	100.0%	**0.0%**	**100.0%**	**100.0%**	**2.4%**	**97.6%**	**100.0%**	**1.5%**	**98.5%**
Asian/Pacific Islander	2	0	2	2	0	2	4	0	4
	100.0%	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**
Am. Indian/ Alaskan Native	4	0	4	5	0	5	9	0	9
	100.0%	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**
Not Specified	4	0	4	0	0	0	4	0	4
	100.0%	**0.0%**	**100.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**
Total	185	5	180	179	13	166	364	18	346
	100.0%	**2.7%**	**97.3%**	**100.0%**	**7.3%**	**92.7%**	**100.0%**	**4.9%**	**95.1%**

Note. Discrepancies are due to rounding. Wasatch Front area includes the following counties: Weber, Davis, Salt Lake, and Utah. MSM stands for "men who have sex with men." IDU stands for "injecting drug users." Unknown in exposure category is risk not reported or identified.

Service gaps listed by highest unmet need are presented in Table 15. The table lists the service gaps of the groups identified as having the highest unmet need. The results support a similar assertion mentioned previously in that a majority of the individuals in the highest unmet need groups are also not using any other services as well.

Table 15
Service Gaps Listed by Highest Unmet Need

	PLWH			PLWA			HIV+/aware Population		
Variable	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**	**Unmet Need**	**Other Services**	**Service Gap**
Gender									
Male	156	3	153	161	11	150	317	14	303
	100.0%	**1.9%**	**98.1%**	**100.0%**	**6.8%**	**93.2%**	**100.0%**	**4.4%**	**95.6%**
Exposure Category									
IDU	36	1	35	43	2	41	79	3	76
	100.0%	**2.8%**	**97.2%**	**100.0%**	**4.7%**	**95.3%**	**100.0%**	**3.8%**	**96.2%**
Geographic Location									
Non-Wasatch Front	27	0	27	30	0	30	57	0	57
	100.0%	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**
Age Group									
10-19	5	0	5	3	0	3	8	0	8
	100.0%	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**
20-29	79	1	78	39	1	38	118	2	116
	100.0%	**1.3%**	**98.7%**	**100.0%**	**2.6%**	**97.4%**	**100.0%**	**1.7%**	**98.3%**
Race/ Ethnicity									
Black, not Hispanic	17	0	17	17	3	14	34	3	31
	100.0%	**0.0%**	**100.0%**	**100.0%**	**17.6%**	**82.4%**	**100.0%**	**8.8%**	**91.2%**
Hispanic	24	0	24	41	1	40	65	1	64
	100.0%	**0.0%**	**100.0%**	**100.0%**	**2.4%**	**97.6%**	**100.0%**	**1.5%**	**98.5%**
Am. Indian/ Alaskan Native	4	0	4	5	0	5	9	0	9
	100.0%	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**100.0%**

Gap Analysis

Gaps in Priority Treatment and Care Services:

Treatment and Care Planners assessed the evidence of the necessity of a service and its availability and accessibility in generating gaps. In addition, they considered in their rankings:

- Impact of the service on Severe Needs Populations
- Barriers in rural communities
- Evidence of the effectiveness of the service
- Particular effect on the health of an emerging population.

The following chart lists the top five priorities for HIV treatment and care services:

1. Health Insurance
2. Ambulatory/Outpatient Medical Care
3. Drug Reimbursement Program ADAP
4. Oral Health
5. Transportation

Health Insurance - Economic downturns have resulted in reductions in the workforce, reduced wages and elimination or curtailing of employee benefits changes in federal as well as state policies for service eligibility. These have significantly decreased the number of clients who hold health care insurance. Those eligible for CARE Act funds—most of whom already face financial challenges—are among the most vulnerable.

As many as 305,000 residents of Utah are uninsured. Further, these changes in eligibility criteria in both the private and public sectors have led to confusion among both clients and providers, leaving some without services even if they are potentially eligible. Further, additional costs, such as “co-insurance”, “prescription co-pay” etc. can transform a $500 yearly deductible to more than $3,000 in out-of pocket expenses in addition to the health insurance premiums.

Treatment and Care Planners ranked the Health Insurance as the first priority for PLWH/A. Out of a possible score of 1,250 (the higher the score the greater the need), they rated the need for Health Insurance 1,129. They rated the availability of the service, 767 and the accessibility at 762, the highest scores among the ranked services. As of July, 2004, allocations for this service will have reached capacity.

Ambulatory/Outpatient Medical Care - The 2003 Utah HIV/AIDS Unmet Need and Service Gap Report (Unmet Needs Report) shows that of the 1,502 known

PLWH/A within the state, 24.2% (364 cases) are not receiving medical care. The 2002 Needs Assessment showed that medical visits and related service were the most used of the Ryan White programs (Medical visits, 89%; CD4 counts, 81%). In Utah, there is only one medical provider who receives Ryan White CARE Act funds and that clinic treats more than 60% of those with HIV/AIDS.

Assuming the current trends of longer life span for PLWH/A, increased testing and possibly growing rates of HIV, and more vigorous attempts to bring those not receiving treatment into care, it is clear that provision of primary medical care will be a critical necessity. As collaborators with the HIV Prevention Program, the Committee also stressed the role of the primary medical provider in offering prevention services to PLWH/A.

Planners ranked Ambulatory Care as the second priority, with the highest need score (1,200 out of 1,250). Availability was scored at 587 and accessibility at 583. The Gap is seen as the need for additional providers, culturally competent providers and greater access for persons in rural areas.

AIDS Drug Assistance Program (ADAP) - Throughout the country, Planners are documenting a crisis in ADAP. In Utah, the ADAP system had reached capacity by July 2004. In 2003, the ADAP expenditures had climbed to $1.13 million serving 321 unduplicated clients of whom 105 were new clients. Annual income of 62.8% of these clients fell at or below the poverty level. With rates of HIV climbing in Utah, it is anticipated that the need for services will continue to rise.

Treatment and Care Planners ranked ADAP third in priority, with a need score of 1137, availability score of 607 and access score of 600. The community rated the impact of Severe Needs Populations with a score of 155 (out of 250), the highest of all categories. These scores reflect the Gap created by increasing incidence of HIV, costs of medications and limited and possibly decreasing funds.

Oral Health Care - The status of dental care is analogous to that of medical care. There are several reports of the need and a serious shortage of providers. Among respondents to the Needs Assessment, 22.3% cited dental care as the most needed service (ranking second among 10 services) and 41% ranked it as a most used service.

Many of the chronically indigent who become eligible for Ryan White services present with a long-standing lack of dental care and their ability to withstand HIV-related oral disease can be seriously compromised as a result. The Unmet Needs Report indicates that of the 364 persons who are not accessing medical care, 95% (345) receive no other services.

These statistics manifest in the decision of Planners who ranked Oral Health services as the fourth priority with a need score of 1,108, availability score of 764 and access rating of 746. Administrative records show that the state expended $293,000 on dental care with a cost per client of $834. Services were provided for 352 patients in 1,272 visits. The most crucial gap in oral health care is in dentists who are willing and competent to serve clients with HIV/AIDS.
This is most true in rural areas. Reduction in other funding sources exacerbates the gap.

Transportation - Access to available services is compromised by limited transportation services in both rural and urban populations. Services to PLWH/A in Utah are concentrated in the few urban areas, especially the Wasatch Front, particularly Salt Lake City. This places rural residents without reliable transportation at a particular disadvantage. Rural residents are confronted with both long distances and seasonal weather conditions that can impede travel.

However, even urban dwellers are faced with the challenge of obtaining services when providers are in locations that are not near their residences nor accessible through public transportation lines. State allocations for transportation totaled

$9,900, the largest proportion allocated to bus tokens ($5,400, $46.48 per client). These allocations served 190 clients in 668 visits.

Planners ranked transportation as the fifth priority. Need was scored 947, availability at 850, and access 841. Special consideration was given to the importance of transportation to rural populations giving this a score of 148 behind only Ambulatory care and Health Insurance.

Comprehensive Needs Assessment

The 2004 Utah HIV Prevention and HIV/AIDS Treatment and Care Needs Assessment was designed to help the Utah HIV Prevention Community Planning Committee and the Utah HIV/AIDS Treatment and Care Planning Committee make evidence based decisions concerning the needs of PLWH/A in Utah. The Utah HIV Prevention Program and the Utah HIV/AIDS Treatment and Care Program, under the Utah Department of Health's Bureau of Communicable Disease Control, managed and funded this project. This needs assessment is the result of a joint collaboration between the Utah HIV Prevention Program, the Utah HIV/AIDS Treatment and Care Program, Clinic 1A at the University of Utah Hospital, the AIDS Education Training Center, and other partners in the HIV/AIDS community. This study is the most comprehensive assessment of the needs of PLWH/A in Utah at this point in time. The quality of this needs assessment reflects the benefits of collaboration between HIV prevention and care.

The survey was pilot tested and the results were highly reliable. There were five constructs in the 2004 Needs Assessment Survey:

1) Usage of services,
2) Accessibility of services,
3) Client satisfaction,
4) Importance of services, and
5) HIV prevention.

Focus groups were conducted to add context to the survey results. A total of 1,218 surveys were distributed from April 30th, 2004 to July 30th, 2004 using purposeful convenience sampling. Surveys were distributed in English and Spanish and survey participants were given a $10 incentive for their participation. A total of 425 surveys were returned (35% response rate) which surpassed the needs assessment subcommittee's goal of obtaining 300 surveys. Only 365 of the survey participants requested the $10 incentive. There were 1,218 PLWH/A invited to participate in the focus groups and only 111 PLWH/A said that they were interested (9.1% response rate). This low response rate might be a result of anonymity or confidentiality concerns.

The research coordinator attempted to create focus groups according to the needs assessment subcommittee's requests, but the PLWH/A who volunteered limited the composition of the groups. The focus groups created included:

1) Two men's groups who were not MSM,
2) Two MSM groups, and
3) One women's group.

Focus group participants were given a $10 incentive.

The quantitative survey results can be generalized to the PLWH/A population in Utah while the qualitative survey results and focus group data is meant to provide context and shed light on the opinions of those that presented them. The survey results were analyzed and descriptive statistics were presented according to target population. The target populations used in the analyses are the priority populations identified in the community planning process. The reference point for all analyses was the entire sample. If the results for a particular group substantially deviated (5% or more) from the entire sample results, the deviation is mentioned in the text of the report. These deviations are also mentioned in the highlights sections of this report.

Based on the responses from the entire sample, the top five treatment and care service ratings were:

1) Doctor visits for HIV/AIDS,
2) CD4 count or viral load,
3) HIV/AIDS medications,
4) Case management, and
5) Food vouchers.

Usage percentages and ratings for importance, accessibility, and satisfaction were high for these five services.

Table 16
Comprehensive Needs Assessment - Treatment and Care Service Ratings: Responses from the Entire Sample

Service	Rank	Usage (%)	Importance (Ave. Rating)	Accessibility (Ave. Rating)	Satisfaction (Ave. Rating)
Doctor Visits for HIV/AIDS	1	88.2	5.8	5.1	5.4
CD4 Count or Viral Load	2	84.9	5.6	5.2	5.4
HIV/AIDS Medications	3	76.0	5.6	4.9	5.3
Case Management	4	70.4	5.3	4.8	4.9
Food Vouchers	5	69.4	5.5	5.0	5.1
Dental Care	6	68.2	5.5	4.5	4.8
Info about treatment	7	58.1	4.9	5.0	5.1
Vision Services	8	56.7	5.3	4.5	4.7
Info about how HIV spreads	9	52.7	4.6	5.2	5.1
Vitamins, Ensure, etc.	10	48.2	5.0	4.4	4.6
Food Bank	11	47.1	5.0	4.4	4.7
Emergency Medical Care	12	45.4	5.2	4.5	4.7
Help taking medication	13	44.7	4.9	4.7	4.6
Mental Health	14	36.7	4.7	4.3	4.3
Nutrition Counseling	15	35.3	4.7	4.7	4.7
Transportation	16	34.4	4.5	3.8	3.9
Help with Housing	17	33.4	5.0	3.9	4.2
Emergency Fin. Asst.	18	29.9	5.0	3.2	3.7
Help Paying for Health Ins.	19	29.9	4.8	4.0	4.5
Legal Assistance	20	20.5	4.7	3.6	3.7
Support Group	21	19.3	4.3	3.4	3.6
Substance Abuse Treatment	22	12.2	3.5	3.9	4.2
Women's Health	23	12.0	3.1	4.6	4.9
Home Health Care	24	9.9	4.1	3.8	3.9
Child Medical Care	25	8.2	3.1	4.5	4.8

Alcohol/Drug Detox	26	4.2	3.1	3.7	3.5

Note: Information presented in the above table represents the survey responses. Rank was established by ranking services by usage and then by importance. All percentages represent the percentage of the particular group. Percentages might not add up to 100% due to the exclusion of non-responses. "Ave. Rating" is the average rating for a particular service category.

What Providers Need to Know

- Focus group participants wanted providers to know that patients need more personal attention, more questions from their doctors and more understanding of the patient's perspective.
- Participants also suggested that an improvement of the continuum of care between providers is needed. Maintaining confidentiality was also a concern.

Medical Care

- IDU and respondents in rural areas were more likely to wait more than six months after diagnosis to receive medical care, as compared to the entire sample.
- Youth and MSM/IDU were less likely to have one place to go for primary medical care, as compared to the entire sample.
- Heterosexuals from communities of color, men from communities of color, and youth were less likely to have received primary medical care, as compared to the entire sample. IDU, MSM/IDU, and youth were less likely to have received antiretroviral therapy, as compared to the entire sample.

Paying for Medical Care and Medications

- Youth were much more likely to be uninsured, as compared to the entire sample.

Skipped or Stopped Taking HIV/AIDS Medication

- IDU, MSM/IDU, inmates in prison or jail, and youth were more likely (as compared to the entire sample) to report that they had skipped or stopped taking HIV/AIDS medications at least once.

Case Management

- Heterosexuals from communities of color, women from communities of color, and MSM from communities of color were more likely to have a case manager, as compared to the entire sample. White women, MSM/IDU, and youth were less likely to have a case manager, as compared to the entire sample. Youth were more likely to report that they don't know if they have a case manager, as compared to the entire sample.
- Heterosexuals from communities of color, youth, IDU, MSM from communities of color, men from communities of color, and women from communities of color were more likely (as compared to the entire sample) to report that they had someone other than a case manager who helps them get services.
- A trend in the data was that communities of color were more likely to have someone other than a case manager who helps them get services, as compared to the entire sample. Another trend was that respondents who are white were less likely to have someone other than a case manager who helps them get services, as compared to the entire sample.
- Men from communities of color and IDU were less likely to have seen their case manager within the past 6 months, as compared to the entire sample.
- Most survey participants were satisfied with case management. Some participants suggested improvements such as better communication, more assistance, more caseworkers throughout the state, more funding, more personal interest, or ensuring that a client only sees one case manager.

Housing

- Inmates in prison or jail, heterosexuals from communities of color, IDU, men from communities of color, MSM/IDU, MSM from communities of color, and women from communities of color were more likely (as

compared to the entire sample) to report that they have been homeless at least once during the past 12 months.

- A trend in the data was that communities of color were more likely to have been homeless at least once during the past 12 months, as compared to the entire sample.
- Respondents in rural areas and respondents that were white were more likely to own a home, as compared to the entire sample.

Food Services

- Food certificates and the food bank were repeatedly mentioned in the focus groups as valuable services.

Barriers to Receiving Services

The top five barriers identified in the focus groups are listed below:

- Maintaining eligibility – Striving to stay eligible for assistance by meeting the income requirements is a barrier.
- Transportation – This was especially a concern if the participant did not live in the Salt Lake area.
- Fear/stigma/prejudice/anonymity/confidentiality – Fear of being identified, fear of rejection, and fear of facing what other HIV positive individuals are going through were some examples of this barrier.
- Copays or spend downs – Copays and spend downs leave little money to live on.
- The lack of resources – Providers want to help, but they don't have the resources.

Other barriers identified in the focus groups are listed below:

- Cost – The cost of HIV-related care is a barrier for consumers, providers, and programs.
- Culture – Culture can be a barrier to receiving services.
- Cap on dental services – The cap on dental services makes it difficult to have expensive dental procedures completed.

- Prison or jail systems – The continuum of care is disrupted when a person is incarcerated.
- Pharmacies – Some pharmacies do not have HIV/AIDS medication readily available.
- Lack of mobility – HIV testing should come to us.

Crosscutting Issues

Crosscutting Issues in HIV/AIDS Treatment and Care

- We need to improve the continuum of care between the major medical providers and other providers.
- Food certificates might be a method for linking respondents in rural areas, men of color, and heterosexuals of color to primary medical care.
- Vision services might be a method for linking IDU to primary medical care.
- Information about treatment might be a method for linking youth to primary medical care.
- Homelessness might be a barrier to linking heterosexuals from communities of color, men from communities of color, IDU, and other groups to primary medical care.

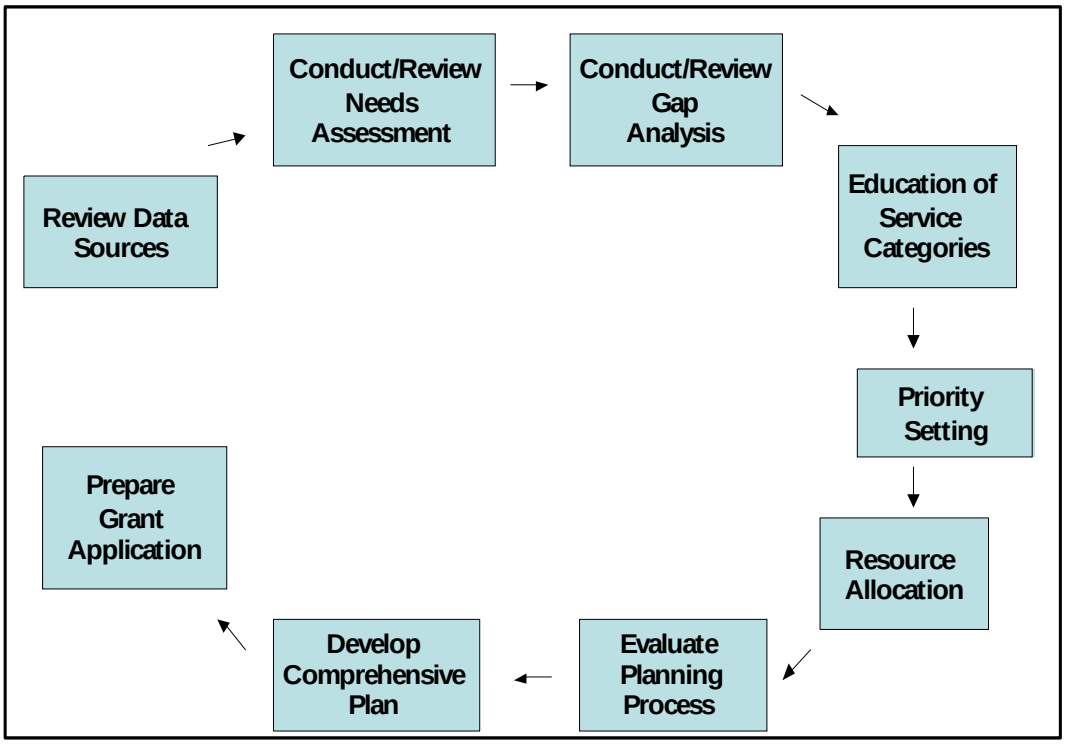
Description of the Current Continuum of Care

Priority Setting of HIV Services

Table 16 depicts the components of comprehensive planning and illustrates the steps of the Treatment and Care Committee Planning process. The products of planning emerge from a standardized method of creating interventions and strategies for HIV treatment and care.

Table 17

TREATMENT AND CARE PLANNING PROCESS



The HIV Treatment and Care Planning Committee spent the first four months of 2005 obtaining background information and educating themselves in HIV/AIDS issues, trends and available resources in Utah.

In March/April 2005 the Committee began work on prioritizing the HIV service categories for Utah (including ADAP, Health Insurance and Supportive Services). The task was of great importance considering the substantial need of services and limited resources available. The Committee members discussed priority setting perspectives and the diverse needs of consumers.

The Priority Setting Process the Committee followed is outlined as follows:

1. Agree on the priority-setting process and its desired outcomes.
    - Write it down

- Include a timetable

2. Discuss conflict of interest.
   - Conflict of interest is present in all planning processes.
   - The greatest risks are within priority setting and resource allocation.
   - Everyone has a role in managing conflict of interest
   - A potential conflict of interest exists when a committee member has a fiduciary interest (e.g. board, staff, consultant, or advisor) to an organization with a direct, personal financial interest in the outcome.
   - Conflict of interest does not usually apply to:
     - Clients of services
     - State personnel when the end point is advisory
   - All committee members must complete a conflict of interest disclosure form prior to beginning the priority setting process.
3. Review relevant legislative requirements and guidance.
   - Clarify the difference between decisions and advisory recommendations.
   - Clarify the difference between priority setting and resource allocation.
4. Discuss available information on “inputs” (information available for decision-making)
   - Epidemiological Profile (Worksheet #1)
   - Needs Assessment (Worksheet #2)
   - Counseling and Testing Data (Worksheet #3)
   - Gap Analysis (Worksheet #4)
   - Other resources
   - Personal and professional experiences
5. Review list of service categories and definitions.
6. Agree on list of principles and criteria the committee will use for priority setting.
7. Part 1 of the priority setting process.
   - Break into groups to facilitate discussion.
   - Use worksheets to inform your discussion.

- Be sure to identify the data source(s) that justify your conclusions.
- Groups will facilitate discussion but your prioritization should reflect your personal opinion (backed up by data), as opposed to a group consensus.

8. Part 2 of the priority setting process.
   - The *Need, Access, Availability* score sheet asks members to assign 10-50 points on each factors (need, access, availability) for each service category, as detailed in the code sheet.
   - Member should consider the principles and criteria when determining scores for each service category.
   - When determining a score, members should note a data source that justifies their score. (e.g. epi profile, comprehensive plan, needs assessment, knowledge of a committee member, etc...)
   - On the *Special Considerations* worksheet, the member can assign an ***optional*** 1-10 points for only those factors that they believe apply
     - Factors:
       - severe need addressed by that service;
       - importance to rural clients;
       - effectiveness of service; or
       - represents an emerging need. Again, these points are optional.
9. Individual scores are entered into a worksheet and tabulated, giving each service category a total score.
10. The entire committee will come together and discuss the service category scores.
11. As individuals, committee members will then rate each service category on the *Priority* score sheet, based on their own opinion of the level of priority of a service. The entire committee will reach consensus regarding the scores for each service category.
12. The prioritized list of service categories will be presented to the Resource Allocation Subcommittee to be used in resource allocation.

A set of qualitative worksheets (Appendix D) were passed out to the Committee and members were asked to evaluate each service category. Once those results were compiled, members were asked to work through a quantitative exercise (Appendix E) to further refine the prioritized list of services.

After the results from both worksheets were calculated, the ranked list was presented to the entire HIV Treatment and Care Planning Committee:

2005-2006 Priority Setting (Final List).

1. Ambulatory/Outpatient Medical Care
2. Drug Reimbursement Program (ADAP)
3. Case Management
4. Health Insurance
5. Oral Health
6. Substance Abuse Services
7. Transportation
8. Mental Health Services
9. Food Bank/Meal Delivery/Nutritional Supplements
10. Nutritional Counseling
11. Outreach Services
12. Housing Services
13. Health Education/ Risk Reduction
14. Emergency Financial Services
15. Legal Services
16. Treatment Adherence Services
17. Early Intervention Services
18. Home Health Care
19. Other Supportive Services (Vision)

Process for Establishing Resource Allocation

In May 2005, the Resource Allocation Subcommittee met to allocate funds to the Ryan White Title II Service Categories. Each member of this subcommittee was asked to declare any conflict of interest they might have. Using the Prioritized Service Category List (above) set by the HIV Treatment & Care Planning Committee, the subcommittee worked through a packet of budget comparisons from current and previous years. With this information, the subcommittee allocated funds to the HIV-related service categories.

These allocations were presented to the entire HIV Treatment & Care Planning Committee in June 2004. The Committee voted to accept the proposed Supportive Services budget for 2005-2006 (see Table 18).

Table 18
RW Title II Priorities & Funding Allocations: April 1, 2006 - March 31, 2007

Service Category	Priority	% of Funds	Dollars
Ambulatory/Outpatient Medical Care	**1**	6.30	$190,653
Drug Reimbursement Program ADAP	**2**	52.93	$1,601,124
Case Management	**3**	8.44	$255,541
Health Insurance	**4**	26.32	$ 796,432
Oral Health	**5**	4.13	$125,000
Substance Abuse Services	**6**	0.66	$20,000
Transportation	**7**	0.33	$10,000
Mental Health Services	**8**	0.49	$15,000
Food Bank/Meal Delivery/Nutritional Supplements	**9**	0.0	$0
Nutritional Counseling	**10**	0.0	$0
Outreach Services	**11**	0.16	$5,111
Housing Services	**12**	0.03	$1,000

Table 18 continued on next page

Health Education/ Risk Reduction	**13**	0.0	$0
Emergency Financial Services	**14**	0.0	$0
Legal Services	**15**	0.0	$0
Treatment Adherence Services	**16**	0.0	$0
Early Intervention Services	**17**	0.0	$0
Home Health Care	**18**	0.16	$5,000
Other Supportive Services (Vision)	**19**	0.0	$0
		100.00	$3,024,861

Resource Inventory (by Service Category)

See Appendices for complete program budgets for Ryan White Title II (Appendix F), Ryan White Title III (Appendix G), Ryan White Title V (Appendix H) and State and Salt Lake City HOPWA Programs (Appendix I & J). Appendix K explores the State Medicaid program including eligibility requirements.

1. Ambulatory/Outpatient Medical Care
    - $190,653 (RW Title II)
    - $854,928 (RW Title III)
2. Drug Reimbursement Program (ADAP)
    - $1,601,124 (RW Title II)
3. Case Management
    - $255,541 (RW Title II)
4. Health Insurance
    - $ 796,432 (RW Title II)
5. Oral Health
    - $125,000 (RW Title II)
6. Substance Abuse Services
    - $20,000 (RW Title II)

7. Transportation
    - $10,000 (RW Title II)
8. Mental Health Services
    - $15,000 (RW Title II)
9. Food Bank/Meal Delivery/Nutritional Supplements
10. Nutritional Counseling
11. Outreach Services
    - $5,111 (RW Title II – Minority AIDS Initiative)
12. Housing Services
    - $1,000 (RW Title II)
    - $422,687 (SLC HOPWA)
    - $152,893.00 (State HOPWA)
    - $38,600 (Shelter Plus Care – Ogden)
13. Health Education/ Risk Reduction
14. Emergency Financial Services
15. Legal Services
16. Treatment Adherence Services
17. Early Intervention Services
18. Home Health Care
    - $5,000 (RW Title II)
19. Other Supportive Services (Vision)

Profile of the Ryan White CARE Act Funded Providers by Service Category

Service Resource Inventory

Each year, the HIV Treatment and Care Program staff update and revise a HIV/AIDS Treatment/Care Resource Directory. The format of this directory focuses specifically on HIV Treatment and Care Services, including Title II Providers, with information about HIV-related services and information that can be accessed by PLWH/A.

The HIV/AIDS Treatment/Care Resource Directory first became available to service providers for distribution to clients/patients and caregivers in July 2000. The directory is updated annually (most recently in December 2005), and service providers should call the Utah Department of Health Bureau of HIV/AIDS toll free number with changes as they occur. In addition, anyone calling the Utah Department of Health, Bureau of Communicable Disease Control toll free number (800) 537-1046 can request a copy.

The resource directory can be easily photocopied by service providers as needed, so that each client/patient receives a copy with current information about available services.

The resource directory is also available on the Utah Department of Health Communicable Disease Control website: http://health.utah.gov/cdc/hivtreatment/hiv_treatment_resources.htm (Click on the HIV/AIDS Treatment and Care Resource Directory 2006 link). This online directory will enable providers and consumers to access the most current resource information available. Changes to information are updated on this website as they occur.

The Title II Providers listed in this directory include:

Case Management

- CHAMP, LLC - Donna Mann
  5620 S Waterbury Way #A202, Salt Lake City, UT 84121
- Clinic 1A, University Of Utah Health Sciences Center
  UUHSC, 30 North 1900 East, Salt Lake City, UT 84132
- Utah AIDS Foundation - Seanna Williams
  1408 South 1100 East, Salt Lake City, UT 84105

Dental Services

- W. Landon Bye, DDS

15 W South Temple, Ste 440, Salt Lake City, UT 84101

- Central City Dental Clinic

  461 South 400 East, Salt Lake City, UT 84111

- Clifford Daines, DDS

  5974 South Fashion Pointe Dr., #230, South Ogden, UT 84403

- Intermountain Dental Health Clinic

  1256 South State Street, Suite 103, Orem, UT 84097

- Gregory Larsen, DDS

  7370 South Creek Road, #104, Sandy, UT 84093

- Mountain Lands CHC - Jason Norman, DDS

  215 West 100 North, Provo, UT 84601

- Eugene Olsen, DDS

  550 East 1400 North, Suite E, Logan, UT 84341

- Gregory Perkins, DDS

  1275 E. Ft. Union Blvd., Suite 215, Midvale, UT 84047

- Stephen Ratcliffe Dental Clinic

  1365 West 1000 North, Salt Lake City, UT 84116

- University Hospitals & Clinics - Dental Clinic #7

  50 North Medical Drive, Salt Lake City, UT 84132

Home Health Care

- Community Nursing Services

Mental Health

- Don R. Austin, LCSW

  1390 South 1100 East #101, Salt Lake City, UT 84105

- Lee Beckstead, PhD - Aspen Grove Counseling

  1400 S Foothill Drive, Suite 24, Salt Lake City, UT 84108

- Jerry Buie, LCSW – Pride Counseling

  4774 Holladay Blvd., Salt Lake City, UT 84119

- Gabriela Cetrola, LCSW - The Diversity Center (bilingual)

  925 East 900 South, #41, Salt Lake City, UT 84115

- Family Counseling Center

5250 S Commerce Drive, Suite 250, Murray, UT 84107

- J Manuel de la Torre, LCSW

  1579 West 600 South, Salt Lake City, UT 84104

- Rebecca Good, ACRN

  7730 South Quicksilver Dr., Salt Lake City, UT 84121

- Inner Traditions Counseling - Cathy Martinez, MSW, LCSW

  807 E South Temple Suite 103, Salt Lake City, UT 84102

- Inner Traditions Counseling - Lee Ann Jones, LCSW

  807 E South Temple Suite 103, Salt Lake City, UT 84102

- LifeChange Family Center - Penelope Eicher, MFT

  437 South Bluff Street, Suite 202, St. George, UT 84 770

- Susan Lyons, LCSW

  1060 East 100 South, Suite L-5, Salt Lake City, UT 84102

- Midtown Community Health Center - Mary Lynn Johnson, LCSW (bilingual)

  670 28th Street, Ogden, UT 84403

- Interwest Counseling Center - John R Shavers, PhD

  4568 Highland Drive, Suite 100, Salt Lake City, UT 84106

- George P. Stoddard, M.A., Ed.S.

  437 South Bluff St., Suite 202, St. George, UT 84770

- U of U Department of Family & Preventive Medicine - Jann DeWitt, PhD

  375 Chipeta Way, Suite A, Salt Lake City, UT 84132

Mental Health Therapy Groups

- Utah AIDS Foundation

  1408 South 1100 East, Salt Lake City, UT 84105

Substance Abuse - ASSESSMENT AND REFERRAL

** Clients residing in the Salt Lake County area must have an assessment completed at the Salt Lake County Division of Substance Abuse before they can access treatment services for substance abuse. Contact Simone Henning below:*

- Division of Substance Abuse Assessment & Referral Unit

  Simone Henning, LCSW (Salt Lake County Govt. Ctr)

  2001 S State Street, Suite S2300, Salt Lake City, UT 84109-2250

Substance Abuse - OUTPATIENT

- Alcohol & Drug Abuse Clinic - University of Utah School of Medicine
  30 North 1900 East #1R52, Salt Lake City, UT 84132
- Lee Beckstead, PhD - Aspen Grove Counseling
  1400 S Foothill Drive, Suite 24, Salt Lake City, UT 84108
- Catholic Community Services - Women's Treatment Program
  2570 West 1700 South, Salt Lake City, UT 84104
- Cornerstone Counseling Center
  660 South 200 East, Suite 200, Salt Lake City, UT 84111
- Interwest Counseling Center - John R Shavers, PhD
  4568 Highland Drive, Suite 100, Salt Lake City, UT 84106

Substance Abuse - OUTPATIENT - METHADONE

- Project Reality – Erin Norris
  150 East 700 South, Salt Lake City, UT 84111

Substance Abuse - RESIDENTIAL

- Catholic Community Services - St. Mary's Home for Men
  1206 West 200 South, Salt Lake City, UT 84104
- The Haven - Pat Guvariria
  974 East South Temple, Salt Lake City, UT 84102

Substance Abuse - RESIDENTIAL/OUTPATIENT

- Family Counseling Center
  5250 S Commerce Drive, Suite 250, Murray, UT 84107
- First Step House (men only) - Robert Simmons
  411 North Grant Street, PO Box 16508, Salt Lake City, UT 84116
- Odyssey House - Glen Lambert
  344 East 100 South, Salt Lake City, UT 84111
- Utah Alcoholism Foundation* - Valerie Fritz
  321 South 600 East, Salt Lake City, UT 84102
  *Locations in Salt Lake, Provo and Ogden

Substance Abuse - MEDICAL DETOX

- Highland Ridge Hospital
  7309 South 180 West, Midvale, UT 84047

- Volunteers of America - Jeffery St. Romain or Shauna Daniels
  252 W Brooklyn Avenue, Salt Lake City, UT 84101

Transportation/Bus Tokens/Cab/Rural Gas Card

- Clients must contact their Case Manager to obtain this service

Barriers to Care

The following barriers were identified in the SCSN process by a focus group specifically assigned to discuss the issue of barriers to care:

- Funding - There are a broad range of issues relating to funding, including, but not limited to: federal funding, co-pays, and spend-down. Several members of the SCSN focus group pointed out the issue that federal funding has not increased as the number of people living with HIV has increased. As stated in the Needs Assessment, providers want to help, but they don't have the resources. The cost of HIV care is a barrier for consumers, providers and programs. The cost of co-pays and spend downs leave little money for consumers to live on and consumers are less likely to access medical care if they are concerned about the cost of co-pays or have no income for co-pays. The HIV Treatment and Care Program encourages case managers to effectively screen clients for eligibility for the range of potential sources of treatment funding, such as Medicare, Medicaid and Veteran's Administration funds. Doing so can enhance access to treatment, helps reduce disparities and effectively leverages CARE Act funds, assuring that they are applied as the payment of last resort.
- Housing - The following point was highly stressed by the SCSN focus group: If you are homeless, getting into care or keeping an appointment is NOT a priority. Additionally, it is difficult for providers to help those that are homeless when they are unable to contact them for appointment reminders and case managers are not able to adequately link them to care.
- Transportation - There are different issues for people in rural vs. urban areas, but issues are difficult for each, just a different set of challenges. The 2004

Needs Assessment ranked transportation as the number two barrier identified in the consumer focus groups, and stated that transportation was especially a concern if the individual did not live in the Salt Lake area. A member of the SCSN focus group stressed that many consumers are unable to afford bus tokens or they cannot afford gas if they have transportation available. There is also a lack of knowledge regarding available transportation resources.

- Substance Abuse/Mental Illness - These are separate services, but need to be dually treated, which makes it even harder for PLWH/A to get care. The HIV Treatment and Care Committee ranked both of these services in the top ten priorities (Substance Abuse: #6 and Mental Health: #8). The Epidemiology Profile indicates that among all admissions in Utah for substance abuse treatment into publicly funded agencies, 44% were for alcohol abuse and 36% were for injection drug use. A comment from the SCSN focus group discussion was that "PLWH/A who have substance abuse issues are more likely to miss appointments when they are high or using frequently because they tend to over-sleep or forget." Clearly, active substance use can compromise treatment adherence, general physical and emotional well-being and places PLWH/A at higher risk of unemployment and homelessness. Another SCSN focus group member noted that "those with mental health issues are less likely to seek care due to the nature of their illness." Even mild depression and anxiety can compromise adherence and can adversely affect immunity.
- Culture/Confidentiality - Both of these are huge issues and were felt to go hand in hand by the small group. One of the biggest problems is that many doctors don't understand the patient's culture and that there is often a language barrier. Other problems can include: stigma of being HIV+, age, ethnic group, jail inmate, and IDU.

SECTION 2

WHERE DO WE NEED TO GO: WHAT SYSTEM OF CARE DO WE WANT?

Continuum of Care for High Quality Core Services

Shared Vision for the Title II Comprehensive HIV/AIDS Plan

During the first year of the HIV Treatment and Care Planning Committee, the members were charged with creating a vision statement that would become the guiding principle for the creation of the Comprehensive HIV/AIDS Plan. The Committee determined that all PLWH/A in Utah should be the focus of their vision. The vision for the Title II Comprehensive HIV/AIDS Care and Services Plan is to:

Ensure the accessibility of quality treatment and care in a manner that ensures dignity for people affected by HIV disease.

Guiding Principles for the Committee Designing the Comprehensive HIV/AIDS Plan

These are the guiding principles that led the HIV Treatment and Care Planning Committee members throughout the planning process as they established the criteria for creating this plan:

As a committee, we will strive to create a plan that will commit resources to:

- ***Serving the under-served***
  All persons living with HIV/AIDS will be offered access to care that is appropriate and broad in scope throughout all stages of their illness.
- ***Ensuring access to treatment and supportive care***
  The coordination of care will meet the needs of, and be accessible to, all populations with HIV/AIDS, all communities, all cultures, and in all geographic locations of Utah.

- ***Adapting to changes in the health care system***
  The delivery system will be flexible, innovative, and efficient in accordance with community-defined standards of care.
- ***Documenting outcomes/results and evaluation***
  The Comprehensive HIV/AIDS Plan will be sustained and supported through community-based collaboration and public/private partnerships with technical assistance to assess client needs, develop and manage cost-effective programs, and evaluate services delivered.

Statewide Coordinated Statement of Need (SCSN)

Consistent with findings across the country, health disparities associated with the economic downturn, inadequate insurance coverage, changes in service eligibility criteria are increasing, especially among the working poor. PLWH/A may be disproportionately affected since they are also confronted with an acute or chronic illness, often with co-morbidities, whose management may require access to very costly medications, frequent contact with health care professions and possible hospitalizations. Further, those who are eligible for CARE Act funding, are often also coping with poverty. To address these concerns, over the course of the year, the Treatment and Care Program will focus its planning and data collection efforts on:

- Defining and understanding the parameters associated with those who are not in care
- Defining and proposing strategies for resolving unmet service needs
- Expanding the collaboration with the HIV Prevention Program and Planning Committee
- Client advocacy
- Program evaluation and recognition of best practices

The HIV Treatment and Care Planning Committee and the HIV Prevention Community Planning Committee believe that these measures will allow them to better implement their essential goal of assuring that all people affected by HIV/AIDS have access to highest quality treatment, care and support.

Service Needs

Utah's successful HIV testing program, which noted an increased HIV positivity rate of 0.4% in 1998 to 0.9% in 2003, and the continued focus on keeping PLWH/A in the system of care has led to an expanding need for a variety services. This is challenging since providers, especially in rural areas, may not be prepared to treat PLWH/A. The various data sources as well as the small group and large committee discussions from the SCSN meeting, call attention to these challenges. The SCSN committee determined the following list to be the community's top five current service needs:

1. Health Insurance
2. Ambulatory Medical Care
3. AIDS Drug Assistance Program (ADAP)
4. Case Management
5. Transportation

Barriers

Information about the barriers related to HIV care came from a range of sources, however, much weight was given to the Needs Assessment as the small group assigned to Barriers discussed and ranked the top five barriers affecting PLWH/A in Utah. This group made the point that these five barriers are from the perspective of the client, not what the Ryan White CARE Act stipulates we spend on what services. The SCSN committee determined the following list to be the community's top five barriers related to HIV care:

1. Funding
2. Housing
3. Transportation

4. Substance Abuse/Mental Illness
5. Culture/Confidentiality

Gaps

As the small group reported their top five gaps in services to the SCSN committee, they noted that they looked at these gaps with the perspective that something is available; there is just not enough of it. The SCSN committee determined the following list to be the community's top five gaps related to HIV care services:

1. Transportation
2. Ambulatory Medical Care
3. Health Insurance
4. Rural Health Care
5. AIDS Drug Assistance Program (ADAP)

Emerging Needs by Population

The SCSN Committee characterized Emerging Needs by analyzing service needs and gaps by sub-populations. Committee members separated into small groups, each targeting one of the four emerging communities: women, communities of color, rural communities, out-of-care PLWH/A. The following lists the sub-populations discussed and their specific needs.

<u>Women</u>

- Access to health care/reproductive health (including abortion & family planning)/STD
- Substance abuse/harm reduction, mental health
- Services for women of color
- Family and child issues
- Poverty/housing issues

<u>Communities of Color</u>

- Legal status/distrust of authority
- Multi-lingual services

- Cultural specific services
- Lack of gender/color specific providers
- Poverty

Rural communities

- Transportation
- Cultural issues unique to Utah
- Lack of confidentiality
- Lack of social support
- Lack of services/quality providers

Out-of-Care PLWH/A

* Note: this list is based on the participant's perspective because we don't know why these people are out of care. Outreach may be an important component in finding out why they are not in care. The reasons vary widely from person to person.

- Fear/Stigma
- Mental Health
- Case Manager
- Funding
- Transportation

Cross-cutting Issues

Cross cutting issues are those factors affecting provision and access to HIV treatment and care, but are external to the direct delivery of health services. During the SCSN development meeting, the full Committee determined the following to be the most important cross cutting issues:

- Poverty/Funding
- Transportation
- Substance Abuse/Mental Health
- Cultural Issues
- Case Management

SECTION 3

HOW WILL WE GET THERE: HOW DOES OUR SYSTEM NEED TO CHANGE TO ASSURE AVAILABILITY OF AND ACCESSIBILITY TO CORE SERVICES?

The goal of the Title II program in the State of Utah is to provide for the development, organization, coordination and operation of a more effective and cost-efficient system for the delivery of essential services to individuals and families with HIV disease.

Goals and Objectives: April 1, 2005 - March 31, 2007

- AIDS Drug Assistance Program:

Goal: To ensure that medications are available to persons living with HIV disease.

Objective: On an annual basis, 340 unduplicated clients will be served through the AIDS Drug Assistance Program.

Timeframe: 04/01/05 – 03/31/06, 04/01/06 – 03/31/07

- Home Health Care Program:

Goal: To ensure that home and community based care services are available in order to reduce hospitalizations for persons living with HIV disease.

Objective: On an annual basis, 5 unduplicated clients will be served through the Home Health Care Program.

Timeframe: 04/01/05 – 03/31/06, 04/01/06 – 03/31/07

- Health Insurance Continuation Program (HICP):

Goal: To ensure that Health Insurance Continuation services are available to provide health insurance coverage to persons living with HIV disease.

Objective: On an annual basis, 100 unduplicated clients will be served through the Health Insurance Continuation Program.

Timeframe: 04/01/05 – 03/31/06, 04/01/06 – 03/31/07

- Supportive Services Program:

Goal: To ensure a continuum of supportive services that link persons living with HIV disease into primary medical care.

Objective: On an annual basis, 450 unduplicated clients will be served through the Supportive Services Program.

Timeframe: 04/01/05 – 03/31/06, 04/01/06 – 03/31/07

- Administration/Planning and Evaluation/Quality Management:

Goal #1: To ensure compliance with the legislative requirements of the Ryan White CARE Act.

Objective #1: On an annual basis, the Title II grantee will comply with all conditions of grant award.

Timeframe: 04/01/05 – 03/31/06, 04/01/06 – 03/31/07

Objective #2: On an annual basis, the Title II grantee will comply with all Ryan White Care Act Agreements and Assurances.

Timeframe: 04/01/05 – 03/31/06, 04/01/06 – 03/31/07

Objective #3: On an annual basis, the Title II grantee will engage in a public advisory planning process including convening the Treatment and Care Planning Committee and holding public information meetings for the purpose of developing a comprehensive plan and commenting on the implementation of such plan.

Timeframe: Meet with HIV Treatment and Care Planning Committee on a monthly basis: January 2006 – June 2006, and thereafter as needed in 2006. Same timeline for 2007.

Objective #4: The Title II grantee will implement and develop the Statewide Coordinated Statement of Need (SCSN) as defined in the guidance by the Health Resources and Services Administration (HRSA). The grantee will review and update the SCSN at least every three years.

Timeframe: the Utah Department of Health (UDOH), the HIV Treatment and Care Planning Committee (Committee), a group of HIV service providers and consumers, members of the HIV Prevention Community

Planning Committee and invited guests will meet to identify significant issues related to the needs of people living with HIV/AIDS in the state and to maximize coordination across the CARE Act titles: just completed SCSN in 2006; next meeting will be in October 2008.

Objective #5: The Title II grantee will establish a quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most current guidelines for treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

Timeframe: The quality management subcommittee will report its activities to the HIV Treatment and Care Planning Committee: June 2006

Objective #6: The Title II grantee will provide for periodic independent peer review to assess the quality and appropriateness of health and support services provided by entities that receive funds from the State under Title II.

Timeframe: December 31, 2006

Objective #7: On an annual basis, the Title II grantee will submit the Care Act Data Report to HRSA.

Timeframe: January 1, 2007

Objective #8: On a quarterly basis, the Title II grantee will submit the ADAP Quarterly Report to HRSA.

Timeframe: 2006 - quarterly

Objective #9: On a semi-annual basis, the Title II grantee will conduct a program needs assessment.

Timeframe: July 2006

Objective #10: On an annual basis, the Title II grantee will conduct program evaluation activities.

Timeframe: December 31, 2006

Objective #11: On a semi-annual basis, the Title II grantee will conduct a customer-satisfaction survey.

Timeframe: Summer 2007

Goal #2: To identify PLWH/A who are not in care and bring them into care.

Objective: On an annual basis, outreach services will be conducted to identify PLWH/A and bring them into care.

Timeframe: 2006 – constant throughout 2006

Goal #3: To continue improving the efforts of the Statewide HIV Planning Advisory Council, which is comprised of the HIV Prevention Community Planning Committee and the HIV Treatment and Care Planning Committee.

Objective #1: On a quarterly basis, the Prevention for Positives subcommittee, made up of members from both the HIV Prevention Community Planning Committee and the HIV Treatment and Care Planning Committee will meet to discuss "HIV Prevention for People Living With HIV/AIDS."

Timeframe: quarterly beginning in March 2006

Objective #2: Integrate the efforts of the HIV Prevention and the HIV Treatment and Care Comprehensive Plans for a 3-year cycle for FY 2006.

Timeframe: December 31, 2006

Goal #4: To further identify PLWH/A by using HRSA's defined Severe Need subpopulations, with definitions of service specific to: use, need, barrier, gaps and demographic measures.

Objective: In FY 2006, use the findings from the 2004 Needs Assessment to develop programs to serve severe need subpopulations.

Timeframe: December 31,2006

Goal #5: To further integrate the Utah Department of Health, Bureau of Communicable Disease Control, HIV/AIDS Treatment and Care Program with the Department of Human Services, Division of Substance Abuse and Mental Health Services.

Objective #1: Further research substance abuse issues for all PLWH/A and by severe need subpopulation level.

Timeframe: December 31, 2006

Objective #2: Determine the extent to which lack of access to this service prevents “Aware and not in Care” in historically underserved or underserved subpopulations from seeking substance abuse services.

Timeframe: December 31, 2006

SECTION 4

HOW WILL WE MONITOR OUR PROGRESS: HOW WILL WE EVALUATE OUR PROGRESS IN MEETING OUR SHORT- AND LONG-TERM GOALS?

Implementation, Monitoring and Evaluation Plans

Evaluation is one of the fundamental elements of the Comprehensive HIV/AIDS Plan. The Treatment and Care Planning Committee and the Utah Department of Health, Bureau of Communicable Disease Control have the primary responsibility for monitoring the progress of the Comprehensive HIV/AIDS Plan's implementation. These two entities will monitor the progress toward achievement of the goals and objectives, continue to gather information and update the Comprehensive HIV/AIDS Plan every three years, and evaluate its own process during the creation of the Comprehensive HIV/AIDS Plan and as the Comprehensive HIV/AIDS Plan is implemented during the next year.

The following section describes how monitoring will take place in four areas:

1) Achieving goals and objectives;
2) Monitoring changes in the epidemic, client's service needs, and service availability;
3) Monitoring changes in legislation, technology, and delivery systems; and
4) Revisions to the Comprehensive HIV/AIDS Plan.

Achieving Goals and Objectives

The HIV Treatment and Care Planning Committee will work in conjunction with the Utah Department of Health, Bureau of Communicable Disease Control to periodically review the status of each objective to ensure that all objectives are being achieved in a timely manner. If problems arise in the meeting of goals and objectives, the HIV Treatment and Care Planning Committee will revise and rewrite any of the goals and objectives considered to be unsuitable/unworkable. Once approved by the HIV Treatment and Care Planning Committee, these

changes will be incorporated into the Comprehensive HIV/AIDS Plan. The HIV Treatment and Care Planning Committee will also compare the goals and objectives to the changing trends in the epidemic and the changing needs of clients and make recommendations/revisions as needed.

The following is a progress report of the 2004-2005 Goals and Objectives:

AIDS Drug Assistance Program:

Goal: To ensure that medications are available to persons living with HIV disease.

Objective: On an annual basis, 225 unduplicated clients will be served through the AIDS Drug Assistance Program.

During the reporting period from April 1, 2004 to March 31, 2005, the AIDS Drug Assistance Program served 341 clients. (A total of 6,986 service units were performed during this reporting period)

Home Health Care Program:

Goal: To ensure that home and community based care services are available in order to reduce hospitalizations for persons living with HIV disease.

Objective: On an annual basis, 20 unduplicated clients will be served through the Home Health Care Program.

During the reporting period from April 1, 2004 to March 31, 2005, the Home Health Care Program served 19 clients. (A total of 471 service units were performed during this reporting period)

Health Insurance Continuation Program:

Goal: To ensure that Health Insurance Continuation services are available to provide health insurance coverage to persons living with HIV disease.

Objective: On an annual basis, 150 unduplicated clients will be served through the Health Insurance Continuation Program.

During the reporting period from April 1, 2004 to March 31, 2005, the Health Insurance Continuation Program served 163 clients. (A total of 1,591 service units were performed during this reporting period)

Supportive Services Program:

Goal: To ensure that a continuum of supportive services are available that link persons living with HIV disease into primary medical care.

Objective: On an annual basis, 750 unduplicated clients will be served through the Supportive Services Program.

During the reporting period from April 1, 2004 to March 31, 2005, the Supportive Services Program served 718 clients. (A total of 8,373 service units were performed during this reporting period)

Minority AIDS Initiative:

Goal: To increase participation of the minority community in the Utah Title II programs.

Objective: On an annual basis, 40 unduplicated clients will be served through the Minority AIDS Initiative.

During the reporting period from April 1, 2004 to March 31, 2005, the Minority AIDS Initiative served 34 clients. (A total of 87 service units were performed during this reporting period)

Emerging Communities:

Goal: To provide ambulatory/outpatient medical care to HIV positive patients in the Salt Lake/Ogden MSA.

Objective #1: On an annual basis, 50 unduplicated clients will receive OB/GYN care.

During the reporting period from April 1, 2004 to March 31, 2005, 72 clients received OB/GYN care. (A total of 86 service units were performed during this reporting period)

Objective #2: On an annual basis, 220 clients will receive primary medical care.

During the reporting period from April 1, 2004 to March 31, 2005, 1,007 clients received primary medical care. (A total of 1,831 service units were performed during this reporting period)

Objective #3: On an annual basis, 100 unduplicated clients will receive case management services.

During the reporting period from April 1, 2004 to March 31, 2005, 300 clients received case management services.

Administration/Planning and Evaluation/Quality Management:

Goal #1: To ensure compliance with the legislative requirements of the Ryan White CARE Act.

Objective #1: On an annual basis, the Title II grantee will comply with all conditions of grant award.

The Title II Grantee (Utah Department of Health) met all conditions of the grant award for April 01, 2004 to March 31, 2005.

Objective #2: On an annual basis, the Title II grantee will comply with all Ryan White Care Act Agreements and Assurances.

The Title II Grantee (Utah Department of Health) met all agreements and assurances associated with the Ryan White Care Act.

Objective #3: On an annual basis, the Title II grantee will engage in a public advisory planning process including convening the Treatment and Care Planning Committee and holding public information meetings for the purpose of developing a comprehensive plan and commenting on the implementation of such plan.

The planning committee meetings served as the public information meeting. The work of the planning committee was completed over a period of nine months and was a large portion of the written comprehensive plan. The Comprehensive Plan Subcommittee, made up of planning committee members, reviewed and edited the Comprehensive Plan.

Objective #4: The Title II grantee will implement and develop the Statewide Coordinated Statement of Need (SCSN) as defined in the guidance by the Health Resources and Services Administration (HRSA). The grantee will review and update the SCSN at least every three years.

The SCSN was updated in October 2005.

Objective #5: The Title II grantee will establish a quality management program to assess the extent to which HIV health services provided to patients under this grant are consistent with the most current guidelines for treatment of HIV disease and related opportunistic infection, and as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvement in the access to and quality of HIV health services.

The Title II grantee (Utah Department of Health) has contracted with HealthInsight to establish a quality management program. The program has been developed and is in the primary stages of being implemented. Preliminary data has been collected and will serve as model for future measure. Ultimately, a Standards of Care document will be written and applied to each supportive service category.

Objective #6: The Title II grantee will provide for periodic independent peer review to assess the quality and appropriateness of health and

support services provided by entities that receive funds from the State under Title II.

Please see Quality Management objective (under goal #1, objective #5).

Objective #7: On an annual basis, the Title II grantee will submit the Care Act Data Report to HRSA.

The Title II grantee (Utah Department of Health) has submitted the Care Act Data Report to HRSA.

Objective #8: On a semi-annual basis, the Title II grantee will conduct a program needs assessment.

The Title II grantee (Utah Department of Health) conducted a program needs assessment during the summer of 2004. A new program needs assessment will be conducted in summer 2006.

Objective #9: On an annual basis, the Title II grantee will conduct program evaluation activities.

The Program Outcomes and Standards of Care were written for all Title II services. Feedback is currently being sought from service providers. An evaluation plan is currently being written.

Objective #10: On a semi-annual basis, the Title II grantee will conduct a customer-satisfaction survey.

The Title II grantee (Utah Department of Health) conducted a customer-satisfaction survey during the summer of 2005.

Goal #2: To continue improving the efforts of the Statewide HIV Planning Advisory Council, which is comprised of the HIV Prevention Community Planning Committee and the HIV Treatment and Care Planning Committee.

Objective #1: On a quarterly basis, the Prevention for Positives subcommittee, made up of members from both the HIV Prevention Community Planning Committee and the HIV Treatment and Care Planning Committee will meet to discuss “HIV Prevention for People Living With HIV/AIDS”.

The 2004 Needs Assessment includes Prevention for Positives questions incorporated into the survey.

Objective #2: Integrate the efforts of the HIV Prevention and the HIV Treatment and Care Comprehensive Plans for a 3-year cycle for FY 2004.

The 2004 Needs assessment is being conducted in collaboration with the HIV Prevention Program and Title III Program.

Goal #3: To further identify PLWH/A by using HRSA’s defined Severe Need subpopulations, with definitions of service specific to: use, need, barrier, gaps and demographic measures.

Objective: Conduct a Qualitative Needs Assessment study in the summer of 2004.

The 2004 Needs Assessment was completed.

Goal #4: To further integrate the Utah Department of Health, Bureau of Communicable Disease Control, HIV/AIDS Treatment & Care Program with the Department of Human Services, Division of Substance Abuse and Mental Health Services.

Objective #1: Further research substance abuse issues for all PLWH/A and by severe need subpopulation level.

Some of these issues were discussed in the SCSN meeting held in October 2005 and will be further explored in 2006.

Objective #2: Determine the extent to which lack of access to this service prevents "Aware and not in Care" in historically underserved or unserved subpopulations from seeking substance abuse services.

Some of these issues were discussed in the SCSN meeting held in October 2005 and will be further explored in 2006.

Monitoring Changes in the Epidemic

Cases of HIV infection and AIDS are monitored by the HIV/AIDS Surveillance Program Manager in the Utah Department of Health, Bureau of Communicable Disease Control on a monthly basis, and epidemiologic trends are monitored annually. The annual HIV Surveillance Report and Community Epidemiological Profile provides information about HIV Infection and AIDS by exposure category, ethnicity, sex, age, and geographic distribution of cases.

The HIV Treatment and Care Planning Committee will monitor the epidemic by reviewing surveillance data and other demographic information, such as income, employment, health insurance, and housing. From this information, the Comprehensive HIV/AIDS Plan will be periodically modified as the epidemic continues to change.

Client Service Needs

Specific goals and objectives have been designed to monitor the degree to which Ryan White Title II funded agencies are meeting the service needs of clients. Client satisfaction surveys and other evaluative tools will be implemented semi-annually. The HIV Treatment and Care Planning Committee will have the responsibility of monitoring this process by reviewing client evaluations and making recommendations to the Utah Department of Health, Bureau of Communicable Disease Control.

Service Availability

Specific goals and objectives have been designed to improve the availability of services to clients by Title II funded agencies. Provider evaluations will be implemented annually to assess the delivery system, and will reflect the guiding principles established in this Comprehensive HIV/AIDS Plan for the system of care. The evaluations will ensure that:

- The care is client-centered.
- The care is comprehensive and inclusive of a wide variety of client needs.
- The care is of the highest quality possible.
- The service providers treat the client in a respectful, dignified manner.
- The services are sustained and supported by other providers in the community.
- The care is designed to be accessible to all persons with HIV/AIDS.

The role of the Treatment and Care Planning Committee is to analyze the results of the provider evaluations and make recommendations to the Utah Department of Health, Bureau of Communicable Disease Control to ensure the highest level of service availability within the fiscal resources of Title II funding.

A statewide resource directory, created by the Utah Department of Health, Bureau of Communicable Disease Control, contains information specific to the

two main areas of the state: the Wasatch Front and the rural/outlying counties. The resource directory will provide up to date service information to case managers and client advocates, which will ultimately assist clients to obtain care services that meet individual needs.

Legislation

With the exception of Medicaid dollars, the majority of HIV/AIDS care services in Utah are provided with federal funds from Ryan White Titles II, III, and Part F Programs and HOPWA. The funds available for HIV/AIDS care are inadequate when compared to the needs of the clients. Therefore, any changes that increase or decrease funds on a federal, state, and/or local level will have significant impact upon the service delivery system.

Changes in legislation that affect funding will be reviewed by the HIV Treatment and Care Planning Committee or the Resource Allocation Subcommittee. Through periodic review, future changes may be anticipated so recommendations may be made to expand or decrease services in accordance with legislative changes.

Technology/Development

Rapid advances in treatment and FDA approved medications are having an impact upon the quality and quantity of life for people living with HIV disease. However, if new medications are to be purchased with Title II funds, less money will be available for other services.

The HIV Treatment and Care Planning Committee and AIDS Drug Assistance Program Subcommittee will periodically review this information, keeping the state formulary up to date.

Service Delivery Systems

Changes in the delivery of services in the two main areas of the state, the Wasatch Front and rural/outlying counties will have an impact upon the health of individuals with HIV disease accessing services in those areas.

The role of the HIV Treatment and Care Planning Committee is to monitor the service delivery systems and make recommendations for cost-effective improvements, based on the values established in the Comprehensive HIV/AIDS Plan for the delivery system of care (client-centered, comprehensive, high quality, respectful, supported by other providers, and accessible to all persons with HIV/AIDS).

Revisions to the Comprehensive HIV/AIDS Plan

During the first quarter of each year, the HIV Treatment and Care Planning Committee will begin to implement the Comprehensive HIV/AIDS Plan. The existing subcommittees (Executive, Policy & Procedure, Resource Allocation & Evaluation, Needs Assessment, Membership, Goals & Objectives, Quality Improvement and Comprehensive Plan) will continue with designated tasks. Additional subcommittees will be formed to divide the remaining work, ensuring that all elements of the Comprehensive HIV/AIDS Plan are fulfilled. See Appendix C for a list of subcommittee members.

During the third and fourth quarters of each year, the HIV Treatment and Care Planning Committee will review, evaluate and make revisions to the Comprehensive HIV/AIDS Plan, utilizing the information gathered under the subcategories listed above.

The Utah Department of Health, Treatment and Care Program will provide the following assistance to the Treatment and Care Planning Committee:

- Staff assistance for the logistical and clerical operations of the Treatment and Care Planning Committee and its subcommittees.

- Technical expertise with respect to the Ryan White CARE Act, budget information, and Title II funded agencies.
- Staff assistance for yearly revisions to the Comprehensive HIV/AIDS Plan.
- Linkage between the service provider network and the Treatment and Care Planning Committee to provide information useful for the decision-making process.
- Provision of epidemiologic, demographic, and needs assessment information as needed by the Treatment and Care Planning Committee for making decisions.

This section has established a foundation about monitoring and evaluating the planning process, as well as the Comprehensive HIV/AIDS Plan itself. Through evaluation, achievements and weaknesses will be identified as the groups work together to meet the goals and objectives of this Comprehensive HIV/AIDS Plan.

APPENDIX A

Utah Department of Health, Bureau of Communicable Disease Control Project Staff

Teresa Garrett, RN, MS	Division Director
Jennifer Brown, MS, JD	Bureau Director

Treatment and Care Program:

Jodie Pond, MPH	Program Manager
Karin Parker	Client Services Coordinator - AIDS Drug Assistance Program (ADAP) - Health Insurance Continuation Program - Premium Payment Program (HIP)
Janene Fontaine	Supportive Services Coordinator - Home Health Care Program
David Antell	Accounting Technician
Rachel Reynolds	Community Health Specialist
Sean Pressey	Research Consultant
Kathy Hills	Office Specialist
Ruth Fullmer	Secretary

Other Program Managers:

Lynn Meinor	HIV Education/Prevention, Program Manager
Rebecca Fronberg	HIV Counseling/Testing
George Usher, MPA	HIV Surveillance, Program Manager
Cristie Chesler	Tuberculosis Control/Refugee Health, Program Manager
Tim Lane	Sexually Transmitted Diseases, Program Manager
Melanie Wallentine	Hepatitis C Coordinator

APPENDIX B

Members of the 2005 Utah Ryan White Title II HIV Treatment and Care Planning Committee

NAME	MEMBER CATEGORY	ORGANIZATION
Duane Abplanalp	Provider	Utah AIDS Foundation
Mauricio Agramont	Advocate	Association for Utah Community Health
Marlin Criddle	Provider	Private Practice - Law
Curtis Day	Consumer	
M Jann DeWitt	Government	AIDSETC – University of Utah Health Sciences
Frank Evans	Advocate	
Wanda Gutierrez	Government	
Linda Johnson	Advocate	Health Insight – Quality Management
Karen Kone	Provider	VA Hospital - Medical
Dennis J Lee	Consumer	
Kenneth P Littlefield	Advocate	
Donna Mann	Provider	CHAMP LLC – Case Management
Leo McCormick	Advocate	
Stuart Merrill	Consumer	
Jodie Pond	Government Committee Co-chair	Ryan White Title II – Utah Dept of Health
Brian Rood	Government	Ryan White Title III – University of Utah Health Sciences
Rita Schluter	Advocate	
Jennifer Shaw	Provider	Community Nursing Services – Home Health Care
Dana Smith	Provider	Clinic 1A, University of Utah Health Sciences - Medical
Pauline Sturdy	Provider	Utah State Prison, Clinical Services - Medical
Cliff Wheeler	Consumer - rural	
Karen Wiley	Provider Committee Co-chair	Salt Lake City Corp – HOPWA - Housing
Seanna Williams	Provider	Utah AIDS Foundation
John Jarman	Alternate	
Rachel Reynolds	Committee Support	

APPENDIX C

2004-05 HIV Treatment & Care Subcommittees:

Policies and Procedures Subcommittee	
Marlin Criddle	Wanda Gutierrez
Rita Schluter	Stuart Merrill
Jodie Pond	Kenni Littlefield

Resource Allocation Subcommittee	
Leo McCormick	Karen Wiley
Darwin Trotter	Stuart Merrill
Rita Schluter	Seanna Williams
Curtis Day	Duane Abplanalp
Dennis J Lee	Franklin B Evans
Dana Smith	Jodie Pond
Karen Kone	

Membership Subcommittee	
Rita Schluter	Franklin B Evans
Curtis Day	Jodie Pond
Wendel Kirkbride	

Goals & Objectives Subcommittee	
Darwin Trotter	Tracy Bunner
Jennifer Shaw	Ron Worthington
Jodie Pond	Karen Kone
Cliff Wheeler	

Needs Assessment Subcommittee	
Jennifer Shaw	Franklin B Evans
Tracy Bunner	Leo McCormick
Jann DeWitt	Jodie Pond

Quality Improvement Subcommittee	
Wanda Gutierrez	Leo McCormick
Tracy Bunner	Karen Wiley
Jann DeWitt	Jodie Pond
Pauline Sturdy	

ADAP Advisory Committee	
Dennis J Lee	John Jarman
Linda Johnson	Curtis Day

APPENDIX D (page 1 of 7)

Name: _____

TREATMENT AND CARE PRIORITY SETTING
PART 1 – QUALITATIVE

Worksheet A: Please discuss the need, availability, and accessibility for each service listed on the worksheet. Remember to provide justification and identify the data sources for your justification. As you complete this worksheet, please identify any special considerations associated with each service.

Definitions

Need

- Meets a documented need or fills an identified service gap
- Essential to the health and well-being of clients
- Decisions are expected to address overall needs within the service area, not narrow advocacy concerns

Availability

- Services are provided across geographic areas
- Services are provided to all sub-populations
- Sufficient service slots are available to meet documented client need

Accessibility

- Consumers know about the service, are able to reach and use it
- Services should be culturally-appropriate
- Services are offered in the preferred language of clients

Special Considerations

- Service is specifically directed to severe needs populations
- Service is especially needed and/or unavailable or inaccessible to rural clients
- Service is documented to be effective in keeping/directing people into medical care
- Service represents a response to an emerging need that reflects changes in local epidemiology of HIV

Worksheet B: Please rank each service based on your discussion in worksheet A. Your ranks should represent your own opinion, which should be supported by your justifications in worksheet A.

APPENDIX D (page 2 of 7)

Worksheet A – Need, Availability, and Accessibility

• Service	• Describe the need, availability, and accessibility of each service (Include justification and data sources)
Ambulatory/Outpatient Medical Care	
Drug Reimbursement Program ADAP	
Health Insurance	
Home Health Care	
Oral Health	
Mental Health	

APPENDIX D (page 3 of 7)

Worksheet A – Need, Availability, and Accessibility **(continued)**

Nutritional	
Substance Abuse Therapy	
Treatment Adherence Services	
Case Management	
Early Intervention Services (EIS)	
Emergency Financial Assistance	

APPENDIX D (page 4 of 7)

Worksheet A – Need, Availability, and Accessibility **(continued)**

Food/Home Delivered Meals/Nutritional	
Health Education/Risk Reduction	
Housing Services	
Legal Services	
Outreach Services	
Transportation	
Other	

APPENDIX D (page 5 of 7)

Worksheet B – Prioritized List of Services

Service (by priority)	Justification and Data Sources
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

APPENDIX D (page 6 of 7)

Worksheet B – Prioritized List of Services **(continued)**

Service (by priority)	Justification and Data Sources
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	

APPENDIX D (page 7 of 7)

Comments, suggestions, reflections, insights, etc.

APPENDIX E (page 1 of 5)

TREATMENT AND CARE PRIORITY SETTING – (Part 2) Quantitative

Data Sources to be considered: Needs Assessments, Counseling and Testing Data, Service Use Data, Comprehensive Plan, Epidemiological Profile, and Committee Discussion

CHART 1	NEED	**Definition:**
		*** Meets a documented need or fills an identified service gap**
		*** Essential to the health and well-being of clients**
		*** Decisions are expected to address overall needs within the service area.**
		Scoring:
		50 Needed by all **40-49 Needed by most** **30-39 Needed in some circumstances** **20-29 Needed by a few** **10-19 Rarely needed**
	AVAILABILITY	**Definition:**
		*** Services are provided across geographic areas**
		*** Services are provided to all sub-populations**
		*** Sufficient service slots are available to meet documented client need**
		Scoring:
		50 Unavailable **40-49 Rarely available** **30-39 Somewhat available** **20-29 Usually available** **10-19 Always available**
	ACCESS	**Definition:**
		*** Consumers know about the service, are able to reach and use it**
		*** Services should be culturally-appropriate**
		*** Services are offered in the preferred language of clients**
		Scoring:
		50 Inaccessible to most **40-49 Rarely accessible** **30-39 Accessible to some** **20-29 Usually accessible** **10-19 Always accessible**

APPENDIX E (page 2 of 5)

TREATMENT AND CARE PRIORITY SETTING

Data Sources to be considered: Needs Assessments, Counseling and Testing Data, Service Use Data, Comprehensive Plan, Epidemiological Profile, and Committee Discussion

CHART 2	SPECIAL CONSIDERATIONS	
		Definition:
		*** Service is specifically directed to SEVERE NEEDS populations**
		*** Service is especially needed, unavailable, or inaccessible to RURAL clients**
		*** Service KEEPS/DIRECTS PEOPLE INTO MEDICAL CARE**
		*** Service represents a response to an EMERGING NEED**
		Scoring:
		7-10 Addresses the consideration
		4-6 Somewhat addresses the consideration
		0-3 Doesn't address the consideration

CHART 3	RATING	
		Definition:
		*** Participant's opinion of the level of priority of a service, based on his/her experience and review of data**
		Scoring:
		50 Highest Priority
		40-49 High Priority
		30-39 Medium Priority
		20-29 Low Priority
		10-19 Lowest Priority
		-10 Do not include

APPENDIX E (page 3 of 5)

PRIORITY CALCULATIONS - CHART 1			
SERVICE	**NEED**	**AVAILABILITY**	**ACCESS**
	10-50	**10-50**	**10-50**
HEALTH CARE SERVICES			
(1) Ambulatory/Outpatient Medical Care			
(2) Drug Reimbursement Program ADAP			
(3) Health Insurance			
(4) Home Health Care			
(5) Oral Health			
(6) Mental Health			
(7) Nutritional			
(8) Substance Abuse Therapy			
(9) Treatment Adherence Services			
SUPPORT SERVICES			
(10) Case Management			
(11) Early Intervention Services (EIS)			
(12) Emergency Financial Assistance			
(13) Food/Home Delivered Meals/Nutritional			
(14) Health Education/Risk Reduction			
(15) Housing Services			
(16) Legal Services			
(17) Outreach Services			
(18) Transportation			
(19) Other			

APPENDIX E (page 4 of 5)

PRIORITY CALCULATIONS - CHART 2 - OPTIONAL POINTS				
	SPECIAL CONSIDERATIONS:			
SERVICE	SEVERE NEED	RURAL	DIRECTS TO CARE	EMERGING NEED
	1-10	1-10	1-10	1-10
	(OPTIONAL POINTS)			
HEALTH CARE SERVICES				
(1) Ambulatory/Outpatient Medical Care				
(2) Drug Reimbursement Program ADAP				
(3) Health Insurance				
(4) Home Health Care				
(5) Oral Health				
(6) Mental Health				
(7) Nutritional				
(8) Substance Abuse Therapy				
(9) Treatment Adherence Services				
SUPPORT SERVICES				
(10) Case Management				
(11) Early Intervention Services (EIS)				
(12) Emergency Financial Assistance				
(13) Food/Home Delivered Meals/Nutritional				
(14) Health Education/Risk Reduction				
(15) Housing Services				
(16) Legal Services				
(17) Outreach Services				
(18) Transportation				
(19) Other				

APPENDIX E (page 5 of 5)

PRIORITY CALCULATIONS - CHART 3	
SERVICE	**PRIORITY**
	(-10) or 10-50
HEALTH CARE SERVICES	
(1) Ambulatory/Outpatient Medical Care	
(2) Drug Reimbursement Program ADAP	
(3) Health Insurance	
(4) Home Health Care	
(5) Oral Health	
(6) Mental Health	
(7) Nutritional	
(8) Substance Abuse Therapy	
(9) Treatment Adherence Services	
SUPPORT SERVICES	
(10) Case Management	
(11) Early Intervention Services (EIS)	
(12) Emergency Financial Assistance	
(13) Food/Home Delivered Meals/Nutritional	
(14) Health Education/Risk Reduction	
(15) Housing Services	
(16) Legal Services	
(17) Outreach Services	
(18) Transportation	
(19) Other	

APPENDIX F

State of Utah 2005 Ryan White Title II Allocations

	Ryan White Title II Base	ADAP	Emerging Communities*	Minority AIDS Initiative**	TOTAL
Administrative Overhead	$101,902	$160,508	$0	$0	$160,508
Planning & Evaluation	$41,344	$60,146	$0	$0	$101,490
Quality Management	$12,940	$7,500	$0	$0	$20,440
ADAP (AIDS Drug Assistance Program)	$0	$1,601,124	$0	$0	$1,601,124
Health Insurance	$203,453	$592,979	$0	$0	$796,432
Home and Community-Based Care	$5,000	$0	$0	$0	$5,000
Supportive Services	$617,194	$0	$0	$5,111	$622,305
Supportive Services Administration	$23,063	$0	$0	$0	$23,063
TOTAL	$1,004,896	$2,422,257	$0	$5,111	**$3,432,264**

** Emerging Communities: Supplemental funds to provide Title II services in the Salt Lake/Ogden area or the MSA (metropolitan statistical area).*
*** Minority AIDS Initiative: Funds provide educational and outreach programs to minority community-based organizations to increase the number of minorities participating in ADAP.*

- Administrative Overhead: Funds, not to exceed 10% of amounts received, are used for administrative activities that include routine grant administration and monitoring activities.
- Planning and Evaluation: Funds, not to exceed 5% of amounts received, are used for planning and evaluation activities.
- Quality Management: Funds, not to exceed 5% of amounts received, are used for quality assurance activities.
- ADAP: Funds provide payment for approved pharmaceuticals and/or medications for persons with no other payment source.
- Health Insurance: Funds provide financial assistance for eligible individuals to maintain a continuity of health insurance or receive medical benefits under a health insurance program, including risk pools.
- Supportive Services: Funds provide supportive services throughout the state.
- Supportive Services Administration: Funds, not to exceed 10% of the supportive services amounts received, are used for supportive services administrative activities that include routine grant administration and monitoring activities.

APPENDIX G

Budget - Ryan White Title III /Award Period 01-01-05 to 12-31-05

Line Item	Primary Care	Other Programs	Administrative	Total
Personnel				
Physician				
Physician				
Bilingual Psychologist				
Neurologist				
Pshychologist				
Physician's Assistant				
Case Management				
Physician's Assistant				
Project Coordinator				
Program Director				
Nutritionist				
Pharmacist				
Case Management				
Acctount Specialist				
Chartroom Specialist				
Sub-Total	$ 301,692	$ 101,029	$ 44,336	
Benefits	$ 78,245	$ 33,036	$ 14,502	
Sub-Total Personnel	$ 379,937	$ 134,065	$ 58,838	$572,840
Travel				
Medical Conference	$ 1,000			
All Titles Conference				
Mileage/Outreach		$ 3,130		
Sub-Total Travel	$ 1,000	$ 3,130		$ 4,130
Contractual				
Primary Care Services - Outside	$ 1,977			
HIV Counseling & Test	$ 6,000			
Specialty Care - U of U Depts.	$ 45,050			
Lab Tests	$ 137,741			
Sub-Total Contractual	$ 190,768			$190,768
Other				
Drugs & Medications	$ 78,690			
Sub-Total Other	$ 78,690			$78,690
Supplies				
Other Program Services		$ 2,000		
Administrative			$ 4,000	
Telephones		$ 2,500		
Sub-Total Supplies		$ 4,500	$ 4,000	$ 8,500
Award Total	$ 650,395	$ 141,695	$ 62,838	$854,928

Compiled by Brian Rood, Ryan White Title III, University of Utah, Division of Infectious Diseases 1/20/06

Appendix H

State of Utah 2004 Ryan White Part F Allocations

Utah AIDS Education and Training Center (UAETC)
Department of Family and Preventive Medicine
University of Utah School of Medicine

Budget Summary for 7/1/04 to 6/30/05

Education Activities **$84,574**

Plan, implement, and evaluate approximately 65 HIV/AIDS education activities for more than 1,300 health care providers and health profession students in Utah, with an emphasis on physicians, physician's assistants, nurses, nurse practitioners, dentists, dental hygienists, pharmacists, and mental health providers, particularly providers in rural Utah. Pay for, and distribute to health care providers educational materials on HIV/AIDS prevention, early identification, and treatment. Travel to education activities in rural Utah. Participate in community planning and other HIV-related community activities.

Administrative Coordination: **$48,760**

Organize education activities, attend weekly UAETC staff meeting, and attend quarterly regional management team meetings.

Minority AIDS Initiative: **$10,000**

Subcontract with Utah Community Based Organization to provide HIV "Train the Trainer" education to at least 50 Latino Community HIV Outreach Workers.

Indirect Costs @ 8%: **$10,666**

Paid to the University of Utah to support the UAETC project.

Total Budget: $154,000

Compiled by Sherrie Kimball, Utah AIDS Education and Training Center11/30/05

Appendix I

State of Utah 2005-06 Housing Opportunities for People with AIDS (HOPWA) Allocations.

Utah State FY 2005-06 (7/1/05 – 6/30/06) HOPWA Program

AGENCY	$ ALLOCATED	FUNDING ID USED FOR
DCC (Department of Community and Culture)	$ 3,330.00	State Administration (3%)
St. George Housing Authority	$ 7,900.00	Long term & Emergency/5 PLWH/A
Salt Lake Community Action Program	$ 15,000.00	Rent/Mort/Util/Emerg/20 PLWH/A
Kenyon Consulting, Inc.	$ 7,000.00	Coord/Resource Identification
Davis County Housing Authority	$ 60,000.00	13 HOPWA Vouchers (for 2 years)
Ogden City Housing Authority	$ 39,663.00	10 HOPWA Vouchers
Catholic Community Services – Ogden	$ 20,000.00	Rent/Mort/Dep/Util/Emerg/20 PLWH/A
TOTAL	**$152,893.00**	

U. S. Dept. of Housing & Urban Development (HUD), Utah State DCC Shelter Plus Care (SPC) Program for PLWHA

AGENCY	$ ALLOCATED	FUNDING ID USED FOR
Catholic Community Services - Ogden	$38,600.00	4-1BR Units/PBRA

PLWH/A—Persons Living With HIV/AIDS
PBRA—Project Based Rental Assistance
TBRA—Tenant Based Rental Assistance

Compiled by Sherm Roquero, Utah Department of Community and Culture1/9/06

Appendix J

Salt Lake City HOPWA Allocations

2005/2006 **Serving Salt Lake, Summit & Tooele Counties** (All funding is for 1 year)

Housing Authority of Salt Lake City	$146,467	TBRA for 21 families/individuals
Robert Willey Apts.	$ 19,500	Project based rental assistance (PBRA)- 4 units for clients
Salt Lake Community Action Program	$150,000	Emergency Rental Assistance/Utility Payments/Support Services for up to 240 clients and their families
Utah AIDS Foundation	$ 15,000	Supportive services for housing related issues for 100 clients.
West Valley Housing Authority	$ 30,600	TBRA for 7 families/individuals
Multi-Ethnic Development Corporation	$ 5,000	PBRA for 3 studio units
Kenyon Consulting	$ 7,000	Housing Coordinator position
Salt Lake County Housing Authority	$ 38,500	TBRA for 10 families/individuals
Administration	$ 16,620	Funds to administer the HOPWA grant
Total:	**$422,687**	

Compiled by Karen Wiley, SLC Corporation 1/9/06

Appendix K

State of Utah Medicaid Plan

To be eligible for Medicaid, an applicant must first qualify for a category of Medicaid established by federal regulations. Each category has requirements concerning citizenship, resources (assets), and monthly income. Medicaid eligibility is determined each month for each individual. Each person applying for Medicaid must qualify under one of the following categories:

- Age 65 or older
- Legally disabled or blind
- Pregnant women
- Child under age 18
- Parent or caretaker of a child under age 19
- Women with breast or cervical cancer

Full Medicaid benefits are available only to U.S. citizens and legal residents. Federal regulations limit an individual's resources to $2,000. For a family, the limit starts at $3,000. Federal regulations also require the state to set monthly income standards which vary based on the category of Medicaid.

A person who does not qualify for a category of Medicaid is considered for the Primary Care Network (PCN) Program. The PCN Program serves individuals age 19 and above with incomes under 150% of the federal poverty level who are not otherwise eligible for Medicaid through the State Plan and who are eligible only through a waiver of federal Medicaid requirements approved by the federal Centers for Medicare and Medicaid Services.

An applicant who has monthly income which is more than the monthly income standard, but less than the amount needed to pay his or her medical bills, may be considered for the Medicaid Medically Needy program. The program is also referred to as the "spenddown" program. To qualify for Medicaid coverage of medical bills, the person agrees to "spend down" his or her monthly income to the Medicaid income standard. The person may choose to either pay "excess" monthly income to the state or to pay a portion of his or her monthly medical bills directly to the medical provider.

A person who is not a citizen or a legal resident may qualify for Emergency Services Program. This program limits benefits to emergency medical services only.

For more information about the Utah Medicaid Program, call the toll-free Medicaid Information Hotline: 1-800-662-9651 or visit their Internet site: www.health.state.ut.us/medicaid.